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THE MEDICAL JOURNAL OF AUSTRALIA

VOL. II.—16TH YEAR. SYDNEY, SATURDAY, DECEMBER 28, 1929. No. 26.

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Table of Contents

An Address.[1]

By MERVYN PATTERSON, M.B. (Sydney),
Retiring President of the Queensland Branch of the British Medical Association.

ACCORDING to precedent the duty of delivering an address this evening devolves upon me. There is only one thing in my opinion worse than having to prepare an address of this description and that is having to listen to one. However, as you are now here, you cannot very well avoid listening and I shall not take more of your time than can be helped.

I have thought that a brief *résumé* of the activities of the Council for the past twelve months might be of interest. A great deal of this will be found in the annual report of the Council, but I would like to discuss a few of the outstanding subjects more fully.

A complaint has been made from time to time that the Queensland Branch of the British Medical Association is run by and for Wickham Terrace. Looking superficially, one can see why such a charge is laid. Practically the whole of the Council consists of Brisbane members, if we except two who come from Ipswich. It appears a pity that the outside members of the Branch cannot be more equitably represented on the Council, but it seems at present that the difficulty is geographical and also at present insurmountable. Any member of the Branch may be nominated and elected to the Council, it is true, but it would be very difficult for members, say, from Toowoomba, Townsville or Longreach to attend fortnightly meetings of the Council.

However, although representation does not appear feasible, the Branch is endeavouring to recognize the claims of the outside members. One meeting of this Branch was held in a far northern town recently and those who attended from Brisbane, reported that it was a most successful meeting. This practice might be continued and extended. Might it not be possible for the Branch to hold one meeting a year outside Brisbane and possibly some of the sectional meetings also? If I can speak for the country members, I feel sure they would welcome such an arrangement. In addition to this the Post-Graduate Committee has a scheme in hand whereby it intends to supply suitable lecturers to give papers at meetings of country local associations. This suggestion was prompted by the local associations themselves and should be of benefit to country members who find it impossible to attend the annual post-graduate meeting in Brisbane. During the year Dr. Michôd, in company with other members of the Branch, visited Lismore by aeroplane and read a paper before the North-Eastern Medical Association.

[1] Delivered at the annual meeting of the Queensland Branch of the British Medical Association on December 13, 1929.

Hospital Practice.

A deputation from the Council waited on the Premier and placed before him and members of the Cabinet a memorandum which was drawn up by the Hospital Subcommittee. This was a very voluminous statement giving instances of injustice and mismanagement of hospital affairs. The hospital group system, as at present carried on, was very strongly criticized, the fact that no income limit was made regarding contributors being the most outstanding injustice to the profession. The South Coast Hospitals Board also was discussed, particularly in its dealings with the Advisory Board. The deputation was given a patient hearing and an assurance that all these matters would be discussed by the Hospital Commission which was shortly to be formed.

We have had many letters from country practitioners who are in difficulties over their hospital appointments. Many of these troubles are caused by men rushing in and signing without fully considering the terms of their agreements. It cannot be too strongly advised that all agreements should be submitted to the Council before being signed. Members have that right and when clauses are inserted contrary to British Medical Association principles, members will be advised; they may then ask their hospital committees to remove these particular clauses. Many country hospital committees are prepared to give their medical officers a fair deal; it is often difficult to get suitable doctors in country districts and a reasonable suggestion for alteration of the terms of an appointment would usually be given reasonable consideration. On the other hand, some committees regard their medical officer as the servant of the committee and as such they are expected to do whatever the committee directs. A body of the kind will expect our members to attend all and sundry in the district and will offer as small a remuneration as they dare. We are looking to the Hospital Commission to bring some uniformity in the agreements of hospital medical officers and to bring to an end the friction and dissatisfaction that most certainly exists at present in many country hospitals.

New Premises.

It was hoped that it would not be long before we would be able to give up our present premises for more suitable ones. "Bayview," on Wickham Terrace, was purchased at a reasonable figure for that purpose. Since the advent of trams in Adelaide Street our present premises have become quite unsuitable for meetings. The Building Subcommittee has advised that no further steps be taken at present, as the time is not suitable for selling our present Adelaide Street property. In the meantime we are drawing a satisfactory rental and the value of the land on Wickham Terrace is improving each year.

Friendly Society Lodge Practice.

As some of you remember, last year was of particular importance on account of the fact that the model lodge agreement was brought into force

in the metropolitan area of Brisbane. A very strong subcommittee was formed to deal with the arrangements and although there was a great difference of opinion on details, there was a remarkable unanimity on the principles of the agreement. A few stray members fell by the wayside, but we do not consider the Branch will be the poorer on that account.

The Friendly Societies' Medical and Hospital Council is now fully established with a large membership and the Branch is in a position to treat all city and suburban lodge matters through this body. As you are aware, before this time there was no authorized body that could speak for the lodge members.

This year, as was only reasonable, the country members were asked to bring their agreements into line. The fixing of the maximum capitation fee was left to the local associations or the individual members in concert where there was no local association. The agreement is now in force practically all over Queensland. In one or two places, where the lodge question is complicated by the hospital group system, members are still working under the old agreement, but we anticipate that this will be altered in the near future.

Personally I was agreeably surprised by the unanimity shown by the outside men in accepting the agreements. It augurs well for the future of the Branch. There were numerous requests for alterations in the agreement to suit local conditions; these were dealt with by the Contract Practice Section of the Branch which during the year took over the functions of the Lodge Subcommittee. The requests of the local associations were granted in most cases, but the vital points in the agreement were strictly adhered to. This firm and unanimous attitude of the members went a long way towards convincing lodge members, if not lodge secretaries, of the justice of our claims.

I think it would be correct to state that a greater proportion of our members does a certain amount of contract practice work. To some it is the foundation of their incomes. It is therefore the duty of the Branch to see that this foundation is not undermined either by lodge officials who consider the financial benefits of their lodges before a good medical service to their members, or by our own members who are willing to sacrifice the Branch and their own professional status in order to gain a temporary advantage over their more loyal fellow practitioners.

MISTAKES I HAVE MADE IN PRACTICE.[1]

By IAN MCNEIL, M.B., Ch.B. (Adelaide),
Honorary Surgeon, Ballarat District Base Hospital, Victoria.

I STARTED to write this paper twelve years ago and when the egotism of youth and arrogance of my first years of practice disappeared, I changed the name to "Some of the Mistakes I Have Made in Practice" and lately I have added "That I Know About."

When I commenced practice I started as an egotist and a know-all, diagnosing every case by spot diagnosis and being quite certain I could cure everything; but alas, my mistakes in diagnosis, prognosis and treatment soon humbled me. For some of the mistakes I have excuses; for others I have no excuse; at least I could not invent one.

I shall try to be perfectly honest and own up to some awful blunders, trusting that my listeners will not be too critical or severe on me. Rather let it be that perhaps this tragedy of errors will act as a preventive to their recurrence on my part and on yours. We all have erred and we all shall err again. I know a prominent medical man who solemnly stated that he had never in all his long years of practice lost a pneumonia patient. Heaven knows what he signed up on some of their death certificates.

In reading the various reports of cases in the various clinical magazines I was struck with the wonderful results and the freedom from mistakes in treatment and diagnosis that the authors claim. It occurred to me also that by publishing more mistakes and less miracles the profession generally would benefit by making known some of the pitfalls that could probably be avoided.

Of course, we have had drummed into us from our early student days some of the mistakes to avoid and the enumeration of a few would not be amiss in this paper. The first is to forget to make a rectal examination in every patient with hæmorrhoids, perhaps missing a rectal carcinoma. The second is to forget to carry out a Wassermann test in a patient with a tumour the origin of which cannot be determined. The third is to give potassium iodide to patients with tuberculosis. Then there is the mistake of not examining the liver of a patient with hæmorrhoids before advising excision. The unsuspected fracture of the base of the skull in the so-called "drunk" may be overlooked. Other mistakes are removing an appendix without microscoping the urine for *Bacillus coli communis* in a doubtful case, forgetting to examine the spinal column and glands in a child with irregular abdominal pains.

But these are all classics and mistakes that should never be made under any circumstances.

It is often not recognizing a simple fact at the first that leads us away from the right path and our subsequent reasoning is all astray. There are two main reasons for the making of mistakes: (i) Inefficient and careless examination, (ii) the fault of the patient perhaps unconsciously misleading the doctor by the way he describes his symptoms, not only by what he says, but by the manner and tone he uses to say it.

Self-confession is good for the soul, but confession to one's colleagues is perhaps good for them and

[1] Read at a meeting of the Victorian Branch of the British Medical Association on October 12, 1929.

one's self as well. If I do seem to be a little bit egotistical, let me say that this paper eventuates partly from a belated realization of the blunders I have made, at least those I know about.

The first case was a street accident. The patient was brought into the surgery at three o'clock in the afternoon with a history of having been knocked down by a motor car. He was a male, forty years, a labourer. His past history contained nothing of importance. He was single. He said it was the first time he had seen a doctor and that his leg was broken. There was a fracture of both bones above the ankle; an X ray examination was carried out and the leg was put up in splints. He was put to bed and said he was comfortable, but still felt dazed. His head was examined for further injuries and the diagnosis of concussion was made and suitable treatment given. I saw him again at 7 o'clock complaining of headache and severe pains all over, but worse in the ankle. A sedative was ordered. At 12 o'clock I was called up to see him and he had quite recovered consciousness and complained of severe abdominal pains. Examination showed rigidity of abdominal muscles, thoracic breathing, elevation of temperature and a rapid pulse. A laparotomy was performed and a ruptured hydatid cyst of the liver was found. The patient got better fortunately, but he was a sick man for years. I was so taken up with the fracture and the concussion that I missed the more serious abdominal condition.

A girl, aged twenty-three, had a lump in the right breast. She had noticed it after a knock four months previously. She said that she did not want an operation unless it was absolutely necessary. There was a small lump under the skin, fairly movable, in the upper and outer quadrant two inches away from the nipple. It was smooth and rounded, not adherent to the skin. I saw it every week for six weeks and there was no change. I advised its removal and examination, indicating to the patient that it was very probably an innocuous cyst and that removal would certainly cure it. After a lot of persuasion and assurance from me that it was a simple matter, she consented. I sent the specimen to a pathologist. Report came back in two words: duct carcinoma. I had then to break the news that my diagnosis was wrong and that a radical operation had to be done to give her a chance at all. The patient is still well after three and a half years. She is having a four monthly course of deep X ray therapy at the Melbourne Hospital at present. There are no signs of recurrence.

I was called in at four o'clock one morning to see a boy aged ten years. It was a very dirty house and a very dirty boy; the light was from two flickering candles. I was told that that day at school he had had a sudden sharp pain in the right side that made him vomit his lunch. He then felt better and played football in the afternoon. He went home and had a meat pie for his evening meal. He went to sleep quite all right at nine o'clock. At half past two he awakened with a pain in his right side and vomited. He said he felt hot and perspiring. At half past three the pain in his side was worse. I saw him at four o'clock. There were rigidity, tenderness and pain over McBurney's point, nausea, a dirty furred tongue and an offensive odour of breath. His temperature was 38·3° C. (101° F.) and his pulse rate 108. There were no physical signs in the chest or heart and no urinary symptoms. Rectal examination revealed nothing abnormal. The knee jerks were equal and active; there was no history of headache, diarrhœa or malaise and no enlarged spleen. He had had attacks of indigestion during the past year. I told his mother that he had acute appendicitis and advised operation at once. His people consented and an appendicectomy was performed. The appendix was not acutely inflamed, but on section showed some slight ulceration. The next morning his temperature was 39·4° C. (103° F.) and his pulse rate was 120 and continued at that rate for three weeks. He developed an enlarged spleen and typical rose spots. His blood on the twelfth day was examined and found to give a Widal reaction. The patient recovered and since then has had rheumatic fever twice. The history of sudden onset with vomiting, the poor light, the dirt on the skin hiding the roseola, the tenderness over McBurney's point, the absence of malaise and headache and no epistaxis all helped me to crash. He was evidently an ambulatory type of enteric. In this case I was quite at sea.

The next case was another trap. A very attractive widow of forty-eight summers, but at the time she owned to only thirty-six springs. Her husband had departed eight years previously. She complained of a lump in her left side with intermittent attacks of pain for over three months, but it had now been constant for four days. She volunteered the fact that she had always been a good woman. Her history was that for the last eight months her periods had become irregular in time and quantity. Then four months ago she had had a hæmorrhage with passage of clots which had lasted for fourteen days. Then she had flushes, attacks of indigestion and flatulence, no morning sickness, no urinary symptoms. She had seen her periods ten days before. She denied any possibility of pregnancy. She had noticed a lump in her left side for six weeks and had seen a doctor in Collins Street who had said she had a growth and that it should be removed. On account of her increased pain I was sent for. I examined her and found a tumour over to the left side, nodular and tender, moderately firm. The breasts had no areola and no milk could be expressed. There was no discoloration of the vulva. The *os uteri* was ulcerated with a lateral tear; there was a slightly offensive discharge which she said she had had for ten years. I diagnosed her case as a pedunculated fibroid, put her in hospital and examined her again. I then arranged for a hysterectomy, had given the anæsthetic and was preparing the vagina when I noticed some clear fluid coming from the cervix which was slightly dilated and I

found a white shining membrane in the cervix. On gently pulling on it, it turned out to be an umbilical cord, much to my embarrassment and consternation which the broad grins of the assistant and nurses only increased. We removed a mummified fœtus and the tumour disappeared. I am afraid I have no excuse for this case except my own carelessness in not going into the history fuller. Finally I consoled myself with the thought that Marie Corelli should have changed the title of her book to "All Women are Liars."

I was called in consultation to see a patient with an acute abdominal condition. Her pulse rate was 100 and her temperature 37·8° C. (100° F.). She had pain in her side, vomiting, rigidity, tenderness over McBurney's point, but no urinary symptoms. She had had four attacks and had been seen by two doctors who had told her she had appendicitis. Nothing was discovered on vaginal examination. I agreed with the diagnosis, laparotomy was performed and a very small normal appendix was found and removed. Further search revealed a pedunculated fatty tumour growing from the omentum that was twisted four complete turns and was rapidly becoming gangrenous. Removal was followed by relief from her symptoms. I suppose this could not be called a mistake except in diagnosis.

I was consulted by a lady of thirty-eight years. She was married and had four children, all well; she had had no miscarriages. She complained of shortness of breath and palpitation, worse on exertion and she had noticed pulsations in her neck. The apex beat was 2·5 centimetres (one inch) below and under the nipple line. The rate was very rapid and irregular, up to 160. There were no bruits; the cardiac dulness was normal. There was no œdema of the feet and no urinary symptoms. The systolic blood pressure was 130 millimetres of mercury and the diastolic 90. I tried her first with four weeks in bed and bromides, digitalis and strophanthus, with no effect. I confess to doing her no good and was not surprised when she called in another medical man who ordered the same treatment with no results. However, she complained of an itchy nose which on examination revealed a perforated septum. Mercury and iodide of potash soon relieved her cardiac symptoms. I must confess that lues had not entered my mind, as her children were healthy and there had been no history of miscarriages. Since then I have had two patients with cardiac symptoms that did not clear up on the usual cardiac treatment; their serum yielded a Wassermann reaction and they recovered after having antisyphilitic treatment.

Here is a lesson I learnt, although it is hardly a blunder. I was doing a *post mortem* examination for the police on a person who had died of a fractured skull caused by an accident. I was making the abdominal incision and the constable who was in charge of the case said: "Let me see you take out a man's appendix, doctor." I found it bound down posteriorly lying over the iliac vessels. I explained how it would have to be stripped off and was doing it when there came a rush of dark blood. I had torn the iliac vein. I am very careful how I handle an adherent appendix, especially if it is in the proximity of the iliac vein. The policeman's only remark was: "Christ, I won't let you take out my appendix!"

I was called to see a girl, aged eight years, complaining of pain in her right hip joint for four days. The history was that she had fallen off a tricycle four weeks before and had hurt her hip badly. She had been in bed for one week. She was allowed to get up and walked seemingly all right except for an occasional limp. Then four days before I saw her the limp had become more pronounced again. She had a cough and was feverish; there was no vomiting, no diarrhœa, no frequency of micturition. She cried when the leg was rotated or abducted. The hip joint itself was tender to pressure over the hip. The father had died from pulmonary tuberculosis and meningitis. Examination of her chest revealed some moist signs at the right apex. I diagnosed an early tuberculous hip disease and said I would make arrangements to have the hip examined by X rays. I was called again later in the evening as the child seemed worse and had vomited. A careful examination of the abdomen revealed rigidity and tenderness over McBurney's point and I had to confess to a change in my diagnosis to that of an acute appendicitis. Laparotomy was performed and a suppurating appendix pointing into the iliac fossa was removed. All symptoms immediately cleared up. The following points led me astray: (i) The tuberculous family history, (ii) the history of injury to the hip, (iii) the pain and rigidity in the leg, (iv) the presence of lung involvement at the right apex, (v) an incomplete and insufficient examination.

My next case was a bad miss. A lady patient, aged forty-eight years, complained of severe indigestion, worse after meals. She felt uncomfortable and full and was not relieved until she belched up wind. She was constipated, said she always had an acid taste in her mouth. She had pyorrhœa. Examination disclosed no other disorder. I had her teeth out under local anæsthesia and a complete set of teeth made and she was dieted. Her condition improved for about two months, then it became worse again. She now said that her indigestion was worse after hurrying or going up steps. Examination of her heart disclosed aortic involvement and no doubt the attack of pain was anginal in character. Rest in bed soon cleared up her so-called indigestion.

A patient, a girl of twenty-three years, was sent to me by another medical man with a tumour in the abdomen. It seemed to extend from the ribs to the iliac fossa and over as far as the mid-line. Her history was that she had had a lump in her left side for four years and that it was gradually growing larger until four days before when it seemed to grow quickly and fill the whole side. She felt unwell and said she felt full. Her temperature and pulse rate were normal. It was diagnosed as a huge

ovarian cyst, two other medical men agreeing. Operation was performed by a lateral median incision practically from the ribs to the pubes. It was found that there were two tumours, one an enormously enlarged spleen, the other a large ovarian cyst arising from the left ovary. The two tumours were touching each other. Both tumours were removed, the ovarian cyst first and then the enlarged spleen. The subsequent history was interesting, as she had fever up to 39·4° to 40° C. (103° to 104° F.) persisting for fourteen days. Roseola spots appeared. She passed sloughs in her stools and a Widal reaction was obtained. The illness then followed the course of a normal enteric fever. The sudden swelling in the last three or four days I took to be a hæmorrhage into the ovarian cyst, but must confess that enteric fever was not even thought of at the operation. I lost trace of her after three years, so do not know the subsequent history.

Two further patients had exactly similar symptoms; the diagnosis and treatment in both were wrong and in fact the wrong diagnosis and subsequent treatment for the one would have been the right diagnosis and treatment for the other and *vice versa*. The patients came to me at an interval of eleven weeks. The history was practically the same in both. Both were married women and both had one child, one aged three years and the other aged four years. They had both missed a period and felt aching pains in their breasts and had frequency of micturition. Both said that they could not possibly be pregnant. The symptoms were complained of after a fall by the one and after carrying a heavy suitcase upstairs by the other. They experienced a severe pain in the lower part of the abdomen and some hours after a hæmorrhage started *per vaginam* which ceased after a couple of hours; then they had three days of irregular pains, but no more hæmorrhage. Then the pains grew worse. I examined them both abdominally and vaginally. The first patient complained of tenderness in the right fornix and a semisolid fluctuation was felt in the right ovarian area; the left side seemed quite clear. Posteriorly in the Douglas pouch no fluctuation could be detected. The *os* had a small right lateral tear with slight ulceration, but no general softening was apparent. The uterus seemed slightly enlarged, but it was doubtful. A consultation was asked for and arranged. It was agreed that the diagnosis was an ovarian cyst. As the pain was becoming more severe, it was thought that it might have a twisted pedicle. Laparotomy was urged and done and a ruptured ectopic gestation was found. The patient made an uninterrupted convalescence for a week, then she started to get the same hæmorrhage which in twelve hours became profuse. She was put on the table again and a piece of decidual membrane was removed. She made a good recovery.

The other patient was seen by the same consultant and thinking of the previous case we were very anxious not to make a mistake and miss an ectopic gestation. The history was very much the same as before, including four days of hæmorrhage and tenderness in the right fornix. The uterus was in good position and not enlarged. The *os* was soft. She had a semisolid mass in the right side and we could feel a fullness posteriorly. There were no urinary symptoms and no breast changes. Her pain increased in intensity and she became rather ill. Her pulse rate increased and she showed signs of shock. There was still a little blood-stained vaginal discharge. We diagnosed a ruptured ectopic gestation. We first dilated and then curetted and removed a normal fœtus. Laparotomy was then performed and an ovarian cyst with a twisted pedicle was removed. Although perhaps we blundered each time, there is probably some excuse for us in the second case, as we were determined to profit by the previous mistake, but I am afraid we carried our zeal too far.

I was consulted by a man of twenty-eight years, a chauffeur, single, who had never been ill until three months previously when he started to get pains in his right side and had vomited. I saw him in two attacks and each time he was tender over McBurney's point. Rectal examination each time failed to reveal any information. Urine was examined microscopically and found to be normal. There was no fever and no increase in the pulse rate. Both his legs were drawn up to ease his pain. The diagnosis of appendicitis was made and he was told that he must have an operation and his appendix removed. He consented and the operation was done a week later after the attack had subsided. The appendix was a very small one, about five centimetres (two inches) long, with no adhesions, and microscopically it showed no changes. As he was coming out of the anæsthetic I had to open his mouth and to pull forward his tongue. I then saw a nice little blue line in his gums explaining his pain as being caused by lead colic. What he wanted was iodine by his mouth and not on the skin.

Another bloomer: I was called in to see a man, aged thirty years, who complained of pain in the abdomen which made him feel sick, but he did not vomit. This was his third attack of pain. There was no fever; his pulse and respirations were normal. There was tenderness just lateral to the umbilicus, but not quite over McBurney's point. There was also a superficial tenderness of the skin over the same area. He said that he always had indigestion after meals. His teeth were decayed and his gums showed signs of pyorrhœa. There was no pain in the upper part of the abdomen. His bowels were constipated; he had to take salts twice a week. His urine was examined microscopically, but nothing pathological was discovered. Nothing abnormal was detected *per rectum*. A diagnosis of chronic appendicitis was made and a laparotomy performed. There were some adhesions from the tip of the appendix to the small bowel. However, he improved with his ten days' rest in bed and light diet and went home

feeling better. He was quite well for two months, when I was called again, as he had had a bad pain again in his abdomen and felt faint. His pulse rate was 150. He felt cold and clammy. He was given ice to suck, 0·015 gramme (one quarter of a grain) of morphine hypodermically and ice packs were applied to his abdomen. Twelve hours after he had melæna. He was afterwards examined with X rays and again operated on and a duodenal ulcer was found. I was not even asked to be present at the second laparotomy and I was told that it was lucky for me that my account had been settled *plus* a few uncomplimentary remarks.

In one hundred years' time, if we could look back, we would probably be disgusted or highly amused with some of the rational treatments adopted at present. There is a tremendous amount of room for improvement in methods, drugs and appliances.

Great strides have been made in all the sciences, but taking one, for instance, engineering, we find the engineer has no doubt used his brain to improve his own machine and having built it, should avoid mistakes and should know its faults before it is in constant use. But we as medical men had nothing to do with the making or building of the machine upon which we have to work. Yet there is no profession which gets less help or encouragement than ours and one mistake may leave us open to anything from adverse criticism to heavy damages.

We live, learn and profit by our blunders and we are supposed to be above mercenary consideration, but having a family to support, one must feather one's nest to a certain extent at the expense of the public's pocket. I suppose there is no profession so much to blame as ours in the matter of running our practices. We have let the public have the idea that to book up half a guinea and pay it in four or five months' time is the usual professional method. I think we are all a poor lot of business men and perhaps I might finish by saying that one of my greatest mistakes was not keeping change of one pound, so that when the fee was ten shillings and sixpence I could give back nine shillings and sixpence instead of a ten shilling note.

This tragedy of errors as I can now perhaps call this somewhat disjointed paper, I hope will teach some of you, if not all of you, as well as myself, to avoid some of the ever-present pitfalls that lie in our way. We must never forget that the patient who is generally notoriously inaccurate in his statements, may be the cause of the mistake.

LEAD THERAPY FOR MALIGNANT GROWTHS.

By D. L. BARLOW, M.C., M.D. (Adelaide),
Adelaide.

MUCH interest has been aroused in recent years by reports of the successful use of lead preparations in the treatment of malignant growths. Very varying results have been obtained by individual workers. Recently in England opportunity was taken to obtain first hand information on the subject, with the result that at least a partial explanation of the conflicting opinions was obtained. Many different forms of lead have been tried since Blair Bell first published his results, but many other workers have attempted to adhere to Bell's methods and to use the same preparation. Considerable difficulty has been experienced owing to the uncertainty of obtaining a satisfactory preparation and it is fairly certain that most of those used have differed considerably from Bell's. At Liverpool it was stated that expert chemists who spent weeks studying the process of making the colloid, were subsequently unsuccessful in their attempt to manufacture it themselves. It is therefore not surprising that others have failed to obtain satisfactory results.

Todd, of Bristol, has been working for some time with lead selenide compounds and has met with considerable success, having shown that regression of the growth takes place in a considerable proportion of cases. There has been an absence of severe reactions such as occurred in many of Bell's patients, and in addition pain has been greatly relieved in many instances. The manufacture of the colloid has been successfully undertaken by a very reliable English firm.

It is by no means supposed that finality has been reached and research is continuing with newer compounds in the hope of finding something still better. The method of employing the present compound will no doubt be modified and improved as a result of experience, but the results so far have justified releasing it for general use by those possessing the necessary facilities.

Method of Administration.

The colloid solution contains 0·4% lead. An initial dose of five cubic centimetres is usual and subsequent doses are given at intervals of a week, the dose being increased by degrees to ten or even fifteen cubic centimetres are given. For sarcoma the increase should be made cautiously on account of the liability to massive necrosis. After eight or ten doses no more is given for two or three months and then a smaller course is given.

Before treatment is commenced, it is necessary to ascertain that the patient's organs are sound and tests of liver and kidney function must be carried out, also a complete blood examination. If there is a serious anæmia, it is not advisable to commence treatment without first doing a transfusion. The urine is repeatedly examined, although albuminuria has been a rare occurrence. The blood examination is repeated at frequent intervals, special note being made of the occurrence of punctate basophilia, the hæmoglobin level and the differential count. It has been noticed in patients reacting favourably that the percentages of small lymphocytes and eosinophile cells tend to increase. Calcium and iodides are given to prevent the lead becoming fixed in the bones. Liver and liver extract are given to combat the tendency to anæmia.

Not all the patients are treated in hospital, some being treated as out-patients. A number of patients who were undergoing treatment, was seen and many of them had improved considerably. It was also ascertained that patients did not find the injections a cause of apprehension on account of after-effects. The impression was formed that this method is of considerable value and should be applied extensively in conjunction, where possible, with surgery. Fortunately the material is stable over considerable periods of time. It is therefore possible to employ the same preparation in Australia as is used in England.

CONCERNING THE SOURCE OF CALCIUM REQUIRED BY THE DEVELOPING CHICK EMBRYO.[1]

By WINIFRED R. MANKIN, M.Sc.,
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As chick embryos are used largely as a source of material for tissue culture experiments and as much work has been done on radiation of the chorio-allantoic membrane in the developing egg, any information we can gain concerning the metabolism of the embryo is important.

This paper deals with the source of the necessary element, calcium, and a suggestion as to its possible mode of transference from the shell to the embryo. The following is a summary of the main work done on this subject by other authors.

Prout[1] concluded from his determinations on eggs at various stages of incubation that lime found in the fully developed chick did not exist in the egg contents before incubation "but is derived from some unknown source during the process of incubation." Voit[2] on the other hand did not find an increase of calcium in the egg contents during development. Vaughan and Bills[3] estimated calcium in three different lots of eggs and three lots of chickens fully developed but unhatched and found that the average amount of lime in one fully developed chick was five and a half times that found in the interior of one fresh egg. Pott and Preyer[4] criticized the work of Vaughan and Bills and from the results which Pott and Preyer obtained, they came to the conclusion that the chick did not contain any more or any less calcium than did the egg contents before development and that the shell of the egg did not lose any calcium during incubation. Carpiaux[5] determined the calcium oxide content of eggs at various stages of incubation and found that it rose from 0·04 to 0·2 gramme during the entire period. A notable increase occurred about the thirteenth or fourteenth day. His analyses of shells before and after incubation did not show any particular change in composition. Delizenne and Fourneau[6] published detailed results concerning the quantitative transference of calcium from the shell to the interior of the egg during incubation. They found that the calcium increase in the egg was progressively greater as the stage of incubation advanced and particularly was this true from the seventeenth to the twenty-first day. They found that the total increase of calcium in the egg during incubation was about 500%. In the non-fertilized but incubated egg the calcium percentage after twenty-one days was exactly the same as in the fresh egg. They did not give results of the determinations of calcium in eggs between the first and tenth days of incubation. Apparently their estimations were carried out on the total contents of the egg at various stages of incubation and not on the separated embryo. The eggs used by these authors were from the same breed of fowl.

Plimmer and Lowndes[7] analysed the egg contents before incubation and at stages throughout incubation and showed that the calcium content of unincubated eggs was about one-fifth of that of a chick about to hatch. They found that there was a trace of calcium in an embryo of the tenth day, an estimable amount on the eleventh day and from thence a steady increase till incubation was complete. No figures were given on embryos earlier than the tenth day. The authors thought that the yolk sac played an important part in the transference of calcium from the shell to the embryo.

With regard to the absorption of calcium from the shell, Buckner, Martin and Peter[8] showed that egg white contained in an egg shell and placed in a jar filled with carbon dioxide at atmospheric pressure absorbed a small amount of calcium (0·007 gramme of calcium carbonate for twenty cubic centimetres of egg white) from the shell. The hydrogen ion concentrations determined colorimetrically were pH 6·0 and pH 8·4 respectively for egg white which had been in an atmosphere of carbon dioxide and egg white which had been in an atmosphere of air. They also showed that if water through which carbon dioxide was passing slowly at the rate of one cubic centimetre per second was allowed to remain in a carefully drained eggshell for four hours at a temperature of 24° C., it would dissolve calcium from the shell as calcium bicarbonate. The hydrogen ion concentration was estimated colorimetrically as pH 6·8. The authors say that

> These experiments give us proof that water containing carbon dioxide passes through both the eggshell membranes to reach the shell and that calcium is dissolved by it from the shell, as calcium bicarbonate, which, by diffusion, passes back through the membranes into the water or egg white contained in the shell. We infer that during the first nine days of incubation, before the allantois had touched the shell membrane, a water solution containing carbon dioxide given off by the embryo diffuses through the white and the membranes to the shell, there forming calcium bicarbonate, which diffuses back to the embryo where it is metabolized. After the ninth day, when the allantois touches the shell membranes, it is reasonable to believe that the shell then gives up calcium bicarbonate to the blood stream as it discharges carbon dioxide.

The conditions in the experiments of these authors were, however, only on the fringe of those in the

[1] This work was carried out under the control of the Cancer Research Committee of the University of Sydney and with the aid of the Cancer Research and Treatment Fund.

actual incubating egg. The rate of production of carbon dioxide in the incubating egg was vastly below one cubic centimetre per second; compare Atwood and Weakly[9] who estimated that a total of ten grammes of carbon dioxide was given off during the incubation. The temperature at incubation was usually about 37° C. and the effect of the presence of other salts in watery solutions in the egg was not considered.

There seems to be little doubt that some of the foregoing authors have proved that calcium is absorbed from the eggshell by the chick. This work has been repeated by the author in somewhat more detail, in that analyses of embryos and not the whole egg have been performed and that the analyses commence on embryos of four days' incubation.

The preparation of material for the estimation of calcium and phosphorus is conducted in this manner. The material is weighed by difference in a silica dish and ashed at a low temperature in the following manner. The dish is placed on quartz pebbles in another silica dish and heated with a low flame till fuming ceases; the dish is then heated with a full Bunsen flame till ashing is complete. After cooling, the ash is extracted with 100 cubic centimetres of half-normal hydrochloric acid. Estimations of phosphorus and calcium are carried out on this extract.

The method for the estimation of phosphorus is as follows. About two cubic centimetres of the cold hydrochloric acid extract (depending on concentration of phosphorus) is evaporated to dryness in a "Pyrex" tube graduated at fifteen cubic centimetres. The residue is taken up with about one cubic centimetre of water. A quantity of a standard solution containing approximately the same amount of phosphorus is placed in a similar "Pyrex" tube. Potassium dihydrogen phosphate is used for the purpose. To the unknown and standard there are then added these solutions in the following order: Three drops of half-normal hydrochloric acid, one cubic centimetre of ammonium molybdate solution (made up according to Briggs's method), one cubic centimetre of a 2% solution of hydroquinone and one cubic centimetre of a 20% solution of sodium sulphite. The tubes are allowed to stand for half an hour and then their blue colours are compared in a colorimeter. Amounts of phosphorus ranging from 0·05 to 0·1 milligramme are convenient amounts with which to work.

The method of developing the blue colour for estimating the phosphorus is practically the same as that suggested by Briggs.[10]

Estimations of calcium have been done on volumes of the acid extract ranging from about two cubic centimetres to twenty cubic centimetres, the actual volume depending on the concentration of the calcium therein. One milligramme to 1·5 milligrammes of calcium are very convenient amounts to estimate. The acid extract is evaporated to dryness in a centrifuge tube of about fifteen cubic centimetre capacity. The residue is taken up with one cubic centimetre of distilled water, to this is added one drop of alizirin indicator and one drop of concentrated ammonium hydroxide. Half-normal hydrochloric acid is then added till the reaction becomes just acid. To the whole is then added one cubic centimetre of 2·5% oxalic acid and two drops of ½% gelatin solution which reduces surface tension and thus helps to prevent the calcium oxalate from floating on the surface. The whole is placed in a water bath and just brought to the boiling point. Two cubic centimetres of 3% ammonium oxalate solution are then added and the bath is boiled for from ten to fifteen minutes. The tubes are removed from the bath and placed in ice cold water and to each is added two cubic centimetres of 20% solution of sodium acetate. The tubes are allowed to stand overnight. Next day the precipitate is centrifuged and washed two or three times with a saturated solution in water of calcium oxalate. The supernatant fluid is withdrawn from the precipitate after each washing by means of a finely pointed glass tube attached to a suction pump. By this method all the supernatant fluid but a fraction of a cubic centimetre can be removed without disturbing the precipitate.

After the final washing the precipitate is dissolved in about one cubic centimetre of 10% sulphuric acid, warmed in a water bath and titrated with centinormal solution of potassium permanganate. A series of blank experiments is performed and the volume of potassium permanganate used (generally 0·175 cubic centimetre) is subtracted from that used in the above titration.

The blank experiment consists of an estimation of calcium on two drops of ½% gelatin solution performed in exactly the same manner as the estimation of calcium on the acid extract.

Accuracy of the Method.

1. The agreement of duplicate results can be seen in Table II.

2. The following shows that calcium added to egg white, egg yolk and chick embryo can be recovered almost quantitatively. The substances (*a*), (*b*), (*c*), (*d*), (*e*), and (*f*) are ashed and extracted according to the method previously described; (*a*) is 13·2761 grammes of egg white; (*b*) is 14·166 grammes of the same sample of egg white as (*a*) to which ten milligrammes each of sodium, potassium and calcium as chlorides are added. The weight of calcium added, expressed as milligrammes per gramme is then $\frac{10}{14 \cdot 166} = 0 \cdot 707$ milligramme per gramme.

Estimations of calcium on (*b*) give the concentration as

$$\left.\begin{matrix} 0 \cdot 730 \\ 0 \cdot 730 \end{matrix}\right\} \text{milligramme per gramme}$$

on (*a*) give the concentration as 0·061 milligramme per gramme.

The added calcium by difference is, therefore:

0·730 − 0·061 = 0·669 milligramme per gramme

which agrees satisfactorily with the actual amount added: 0·707 milligramme per gramme.

Substance (*c*) consists of 7·120 grammes of egg yolk; (*d*) consists of 6·391 grammes of the same sample of egg yolk as the above with ten milligrammes each of sodium potassium and calcium as chlorides.

Estimations of calcium on (*c*) give the concentration as: 1·03 milligrammes per gramme and on (*d*) as 2·572 milligrammes per gramme.

The added chloride by difference is then:

2·575 – 1·03 = 1·545 milligrammes per gramme

Actual amount of chloride added:

$\frac{10}{6·391}$ = 1·570 milligrammes per gramme

Substance (*e*) consists of five ten-day embryos weighing 13·6421 grammes; (*f*) consists of four ten-day embryos with ten milligrammes each of sodium potassium and calcium as chlorides.

An estimation of calcium on (*e*) gives the concentration as 0·326 milligramme per gramme and on (*f*) as 1·350 milligrammes per gramme.

Added calcium by difference is, therefore:

1·350 – 0·326 = 1·024 milligrammes per gramme

Actual amount of calcium added:

$\frac{10}{10·6361}$ = 0·941 milligramme per gramme

The recovery in (*f*) is as accurate as one can expect under the circumstances, if one remembers that eggs incubated for the same time do not necessarily contain embryos of exactly the same age. The absolute age of embryos depends on the history of the egg previous to incubation; from this it can be seen that the embryos in (*e*) and (*f*) may not contain exactly the same percentage of calcium.

In Table I the percentage of solid and the calcium content of egg whites and egg yolks laid by the same fowl are set out. It is seen that the calcium is located mainly in the yolk and that the percentage of solid is much higher in the yolk than the white. Taking the average weight of yolk as twenty grammes and its average calcium content as one milligramme per gramme, the total calcium content in yolk is twenty milligrammes. Similarly taking average weight of white as thirty grammes and its average chloride content as 0·1 milligramme per gramme, its total calcium content would be three milligrammes. The total calcium contained in egg contents is 3·0 + 20 = 23 milligrammes.

TABLE I.

Eggs laid by one fowl. P series (assumed fertile).
Average weight of yolk, twenty grammes. Average weight of white, thirty grammes.

When Examined.	Calcium milligramme per gramme Yolk.	Calcium milligramme per gramme White.	Solid percentage Yolk.	Solid percentage White.
The day laid ..	0·900 0·954		51·8	11·5
One day after laying	1·15 1·18	0·120 0·130	53·0	10·7
One day after laying	1·33 1·28 1·32 1·35	0·205 0·206	53·4	11·2
Five days after laying	1·03 1·01	0·114 0·108	50·8	11·6
Four days after laying	1·23 1·18 1·20	0·085 0·076	51·8	10·8
Egg incubated one day	1·25 1·21 1·23	0·068 0·074	51·0	11·0
Egg incubated one day	1·07 1·09	0·064 0·064	51·3	11·7
Egg incubated two days	1·22	0·062 0·058	51·5	12·8
Egg kept about one month	1·27 1·23		48·0	12·5

In Table II are given the results of a series of determinations of calcium and solid on embryos of different ages. Eggs labelled by the same letter were laid by the same fowl. On examining Table II we find that the embryo becomes drier and that its calcium percentage rises as it becomes older, the difference in calcium content being much more noticeable when expressed in terms of wet weight than dry weight. Assuming that the average weight of a chick just hatched is thirty-five grammes and its calcium content is three milligrammes per gramme, the total calcium content is 105 milligrammes which is vastly in excess of the twenty-three milligrammes shown in Table I to be present in the egg contents before incubation. Therefore about eighty milligrammes of calcium are absorbed from the shell

TABLE II.

Embryo Series and Number of Embryos Used.	Age of Embryo, Days.	Weight of Wet Embryo.	Weight of Dry Embryo.	Percentage of Water.	Calcium milligrammes per gramme Wet Embryo.	Calcium milligrammes per gramme Dry Embryo.	Weight of Calcium per Embryo, milligramme.
Mixed (73)	4	10·5126	0·5388	94·9	0·320	6·28	0·046
Mixed (71)	5	13·0097	0·7616	94·15	0·330	5·64	0·060
Mixed (35)	6	17·8249	1·0263	94·24	0·22	3·84	0·112
Mixed (27)	7	18·4720	1·1137	93·97	0·44	7·32	0·300
Mixed (15)	8	15·1491	0·9721	93·60	0·24	3·80	0·242
Mixed	9	18·7676	1·2599	93·28	0·33	4·92	
C18 (8)	9	14·8500	0·9600	93·54	0·20	3·04	0·372
D11 (5)	9	9·6895	0·6385	93·40	0·47	7·12	0·911
C11 (3)	10	8·8034	0·6386	92·74	0·35	4·85	1·03
P4 (1)	10	3·256	0·2436	92·60	0·44	5·97	1·43
C10 (1)	11	3·8326	0·2674	93·00	0·37	5·27	1·41
C19 (2)	12	12·4972	1·0582	91·5	0·83	9·76	5·19
D14 (2)	12	10·7822	0·7562	93·00	0·72	10·3	3·87
C9 (1)	13	5·9470	0·5486	90·76	0·70	7·58	4·13
D3 (1)	13	6·06	0·4040	93·33	0·91	13·65	5·51
C7 (1)	14	5·3500	0·6100	88·5	1·25	10·8	6·68
C5 (1)	16	14·9364	2·6614	82·1	1·83	10·2	27·3
D2 (1)	16	8·0400	1·63	79·7	2·76	13·6	22·2
P76[1] (1)	16	15·2140	2·7664	81·8	1·47	8·05	22·3
C6 (1)	17	20·5474	3·6650	82·2	2·22	12·5	45·5
P78[1] (1)	17	14·5360	2·9590	79·6	2·36	11·6	34·3
C2 (1)	17	18·5472	3·2860	82·3	2·1	11·9	39·0
C3 (1)	18	20·7328	3·7016	82·2	2·1	11·7	43·5
Px_3 (1)	18	23·4614	4·8434	79·4	2·4	11·6	56·3
C8 (1)	19	22·5770	4·3488	80·7	2·73	14·15	61·6
D9 (1)	19	28·7010	4·1840	78·3	2·19	10·1	62·9
P75[1] (1)	19	27·2558	5·7820	78·8	4·05	19·1	110·0
P79 (1)	19	23·9640	4·9915	79·2	3·16	15·1	75·6
C1 (1)	20	31·8346	7·2396	77·2	2·25	9·85	71·6
D1 (1)	20	25·6070	6·3890	75·0	3·95	15·80	101·0
D4 (1)	20	39·3506	9·6846	75·4	3·27	13·3	129·0
D6 (1)	20	39·2702	9·8162	75·0	3·91	11·6	154·0
D8 (1)	20	22·8794	4·4924	80·3	2·65	13·4	60·6
P66 (1)	20	25·7932	5·8846	77·2	4·32	18·9	112·0
D7 (1)	21	34·4500	9·1435	73·9	3·36	12·8	124·0
Px_4[1] (1)	21	35·3182	6·9212	80·4	2·93	15·0	103·5
P80 (1)	21	29·2154	6·2824	78·5	4·31	18·9	126·0
C14	Just hatched	31·07	9·8831	68·2	3·81	12·1	118·0

[1] Embryos were dead when the shell was opened.

during incubation. A further examination of the results shows a definite rise in the percentage of calcium contained in the embryo on about the twelfth day and as the yolk apparently does not lose any of its calcium and as the white contains only a trace (Table I) this element must be absorbed from the shell at the beginning of calcification of the embryo.

Concerning the Absorption of Calcium by the Embryo.

The figures shown in Table II indicate that there is a rise in the calcium content of the embryo on about the twelfth day of incubation and that this increase continues till the chick is fully developed and further that the fully developed chick contains about five times as much calcium as does an unincubated but fertile egg.

It is suggested that the calcium is absorbed by the allantoic fluid from the shell as a mixture of possibly calcium bicarbonate and calcium hydrogen phosphate ($CaHPO_4$). The evidence upon which this suggestion is based is as follows:

1. Unlike the yolk sac, amnion and chorion, the allantoic sac is developed from the embryo itself. Functionally it is primarily the embryonic respiratory organ, but it also serves as a reservoir for excretory products. On about the eleventh or twelfth day of incubation we find the allantoic sac completely lining the inside of the shell and as it is about this date that the first absorption of calcium by the embryo is noted, the calcium must pass through the allantoic fluid to get from the shell to the embryo.

2. It is known that carbon dioxide is given off continuously during incubation (Atwood and Weakly) and it is therefore thought that the allantoic fluid would be saturated with carbon dioxide at 37° C. and hence sufficiently acid to dissolve calcium and phosphorus from the shell.

3. As a result of a number of determinations by the author, on the solid, phosphorus and calcium content of allantoic fluid from eggs containing embryos six to seventeen days old it has been found that the solid content is generally about 1% to 2%, the phosphorus concentration one decimilligramme per gramme and the calcium concentration one decimilligramme per gramme.

Summary.

1. A method dealing with the accurate estimation of calcium in tissue is described.

2. The calcium content of the yolks of unincubated eggs is about 0·10% and that of egg white about 0·01%, so that the total calcium content of an unincubated egg approximates twenty-three milligrammes.

3. The calcium content of a newly hatched chick is about one hundred and five milligrammes.

4. The average water content of yolk is 49%. The average water content of white is 89%. The average water content of a four-day embryo is 95%. The average water content of a newly hatched chick is 69%.

5. The presence of calcium in the yolk of the incubated and developing egg in concentration similar to and greater than that of the non-incubating egg is indicated as is also the presence of calcium and phosphorus in the allantoic fluid.

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Reports of Cases.

TWO CASES OF COMPOUND, COMMINUTED, DEPRESSED FRACTURES OF THE CRANIAL VAULT.

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Case I.

L.V., AGED ten years, was admitted on December 20, 1928, with a history of having been knocked down by a tram. He was unconscious, restless and bleeding from his nose and left ear and had a wound in the region of the left parietal boss and lacerations to both feet.

On examination the pupils were equal and reacted to light. He was unconscious and restless and had no paralysis of limbs. There was hæmorrhage from the nose and the left ear. The scalp wound was stitched by the house surgeon and morphine hydrochloride 5·4 milligrammes (one-twelfth of a grain) given. Three days later the patient was seen by Dr. R. B. Wade, Senior Honorary Surgeon. Sepsis in the scalp wound had then occurred and he decided that owing to this, exploratory operation was contraindicated. The patient's condition alternated between total and semiconsciousness and the pulse did not drop below 100. On the sixth day lumbar puncture was performed and 45 cubic centimetres (one and a half ounces) of clear cerebro-spinal fluid under increased pressure were withdrawn. The patient was slightly relieved,

but soon became restless again. His condition was now very grave. He tore off all his dressings, became emaciated and had to be fed by a tube; also he had to be tied to the bed and screamed and writhed in bed practically continuously day and night. His wound was pouring pus and as he generally succeeded in knocking off the dressings it was very difficult to nurse him.

As Dr. Wade was on holidays the patient was placed under my care. About the middle of January his pus discharge lessened and finally disappeared. Dr. Wade was informed that the pus had ceased and he advised that a decompression operation be performed. Operation was undertaken by me on January 18. A large flap was turned down over the scalp wound and bleeding was controlled. Beneath the wound in the scalp a flake of bone, composed of outer table and diploe, was found resting on a bed of granulation tissue about the region of the parietal eminence. This was removed. Leading from this downwards and anteriorly towards the left temporal squame was a fissured fracture. At the end of this the temporal squame was found practically in small pieces. Instead of being normally overlapped, the superior edge was driven beneath the parietal bone and below a spicule of bone had penetrated the *dura mater*. All these fragments were removed and a capillary drainage tube was placed in the lower angle of the wound. The patient was returned to the ward in a moderately good condition. No change was noted the following day, but his intervals of screaming became less. In one week he began to take some interest in his surroundings. Soon afterwards he appreciated the meaning of words, but could not answer intelligently. He was taught to count and to repeat simple phrases and rapidly progressed. His wound healed well. His progress was now rapid and recovery was complete. He was discharged on February 16, 1929, and now attends school. He was seen lately and is a normal, intelligent, growing boy and has apparently no mental deficiency whatsoever. A recent skiagram shows that the gross cranial defect has partially closed.

Case II.

H.J., a school boy, aged twelve years, was admitted on July 20, 1929, with a history of having been pillion-riding on a motor bicycle and having been thrown off on to the back of his head. When seen about half an hour after his admission, he was observed to have a large hæmatoma over the left parietal region with a small penetrating wound in the centre which was bleeding freely. He was quite unconscious, the left pupil was dilated and he was paralysed in both right arm and leg. His temperature was 36·0° C. (96·8° F.), and pulse 88 in the minute and very thready and weak. Immediate operation was performed. A large flap was turned down in the left parietal region and the skull exposed. An extensive triradiate fracture was then seen. One limb of the fracture passed down towards the base of the skull, a second laterally over the upper limits of the occipital bone and a third forwards verging towards the mid-line. These fissures averaged 11·25 to 12·5 centimetres (four and a half to five inches) in length. The two posterior fissures converged towards the centre of the injured bone and made practically one continuous line of bone cleavage, meeting at an obtuse angle. Also the bone posterior to this line of cleavage was driven under the bone anterior to the fissures to the extent of about 1·25 centimetres (half an inch). It was found also that a portion of bone at the junction of the three fissures had become detached in a quadrate form and had been driven deep to the overlap just described. Thus where one layer of skull thickness is normally present, there were in reality three, the massive overlap and the detached portion, about 3·75 centimetres (one and a half inches) square, deep to it. An elevator was inserted into the fissures on each side of the centre depressed portion and rotated simultaneously and the overlap was thus corrected. It was then found that the centre detached portion could not be withdrawn owing to its edges being bevelled. Small arcs were therefore nibbled from adjacent bone and the fragment was gently insinuated through these apertures and extracted. After some deliberation this fragment, 3·75 centimetres (one and a half inches) square, was replaced and it fitted perfectly, the edges being bevelled. The *dura mater* was not lacerated and did not bulge. The following morning the patient was quite conscious and his paralysis had disappeared. He was able quite easily to button up his pyjama coat *et cetera*. He complained of some slight weakness of the affected side, but this soon disappeared. He made an uninterrupted recovery, the scalp wounds healed by first intention and he was discharged on September 2, 1929.

Skiagrams were taken every fourteen days to ascertain if the loose fragment showed any signs of necrosis. None was revealed, however, and at the present date, October 21, 1929, X ray examination reveals firm union of all fissures and the detached fragment. His parents also report that his mental condition is in no way different from that existing prior to his injury.

The case presents some interesting features owing to the massive trauma sustained to this skull and the uneventful convalescence with apparently at this juncture no signs of ill effect.

Acknowledgement.

I am indebted to Dr. R. B. Wade, Senior Honorary Surgeon, for his permission to publish the report of Case I.

CONGENITAL DIAPHRAGMATIC HERNIA.[1]

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E.A., *ætatis* forty-eight, a female, single, whose occupation was stated to be domestic duties, was admitted to the Royal Prince Alfred Hospital on February 12, 1929, complaining of vomiting for three months.

The history elicited was that she had been subject to nervous dyspepsia all her life with occasional attacks of vomiting which lasted some days. For three months

FIGURE I.
Showing Appearance found when the Abdomen was opened. Only dilated stomach, duodenum and descending colon could be seen.

[1] The specimen described in this report was shown at a meeting of the New South Branch of the British Medical Association on May 16, 1929.

before admission she had been vomiting almost continuously, usually in the evening, large quantities of undigested food. Only occasionally did she have pain before the vomiting. Loss of weight amounted to 18·9 kilograms (three stone) in three months.

On examination the patient was very thin. Nothing abnormal was found in examination of the alimentary system, nervous system, on vaginal or rectal examination or in the urine. Cardiac dulness extended five centimetres (two inches) to the right of the sternum and the left side of the chest was resonant, with diminished breath sounds.

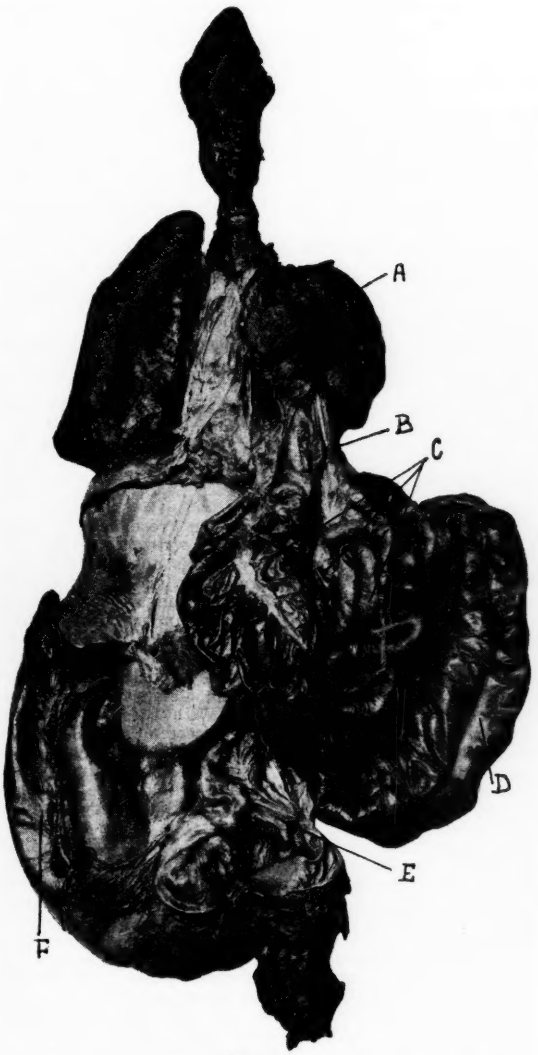

FIGURE II.

Showing Appearance of Viscera, Anterior View. The coils of intestine comprising the jejunum, ileum, ascending and transverse colon and part of the descending colon have been removed from the thorax and turned down. A = collapsed left lung; B = band of adhesion; C = coils of small intestine and ascending and transverse colon turned down from thorax; D = descending colon; E = sigmoid flexure; F = hugely dilated stomach.

A fractional test meal eight days after admission revealed no abnormality. A bismuth meal X ray examination one week after admission revealed a very atonic stomach with definite duodenal stenosis.

At operation nine days after admission under ether anæsthesia induced by the open method a left diaphragmatic hernia was discovered. The stomach and first part of the duodenum were both enormously dilated and the second part of the duodenum was acutely kinked on the first as it ran upwards and to the left. The small intestines and ascending and transverse colon were the main contents of the hernia. The ovaries were in the lumbar region. Neither the duodenum nor jejunum could be brought down to enable a gastro-jejunostomy to be performed. The whole mass of bowel was adherent in the thorax.

FIGURE III.

Showing Appearance of Viscera, Posterior View. A = Intestines turned down from thorax; B = dilated stomach.

After operation the patient did not improve. Vomiting was persistent and the patient died one month after operation, completely emaciated. A skiagram taken of the thorax two weeks after operation revealed some unusual shadows on the left side, probably due to opaque contents in the small bowel, and it was suggested that there was a partial pneumothorax in the left upper lobe.

At *post mortem* examination the left pleural cavity was found to contain only a small portion of collapsed lung and practically all the large and small bowel. The hernial opening was in the centre of the left dome of the diaphragm. The stomach was greatly dilated and filled the peritoneal cavity.

In the accompanying illustrations the condition may be well seen.

Reviews.

A BOOK ON CANCER.

IN "The Conquest of Cancer by Radium and Other Methods"[1] the author, Dr. Quigley, covers even a wider field than the title might suggest. His opinions of the ætiology of cancer are crystallized in the statement that any germ may become localized in any part of the body and produce the necessary irritating toxins which set in motion the processes that become cancer. Similar dogmatic statements recur throughout the book, like islets in the author's verbosity.

It would be idle for any radium therapist to seek here for any detail of the methods used or the techniques employed. In no case is filtration mentioned and even the manner of application and the form in which the radium was used, are often omitted. For example a patient suffering from "malignant disease of the skin" was treated with "125 milligrammes of radium sulphate" for ten days "about two hours each day." It is needless to comment that such a description of treatment is utterly valueless and unscientific and can only be compared with that of a cardiologist saying that he gave his patient "a handful or two of digitalis leaves." Further, the author has a fine old fashioned contempt for those who make "a fetish of the microscope while there are enormously more important methods of making a diagnosis," which the author keeps to himself. Assuredly the best statistics in the treatment of cancer by any method are to be obtained in those cases where no biopsy was made. The edifice of modern radiation therapy rests on a basis of histological knowledge and the future developments depend on the more precise classification of tumours according to their radio-sensitivity. If the scientific elements are wanting in this publication, there is also absence of any literary grace. On the very first page the expression "get-at-able" is used and later a reference to the "dead carcass" of cells might be considered unsuitable even in the daily press.

The book, like so many American publications, is excellently printed and many fine illustrations adorn a text that is without value, since it will not convince those who are sceptical of the value of radium nor enlighten those who already believe in it.

SCIAMACHY.

THE mysterious title of Dr. Higgins's book, "Biological Reversion and Hippocratic Anatomy," gives but little clue as to its contents.[2] Fortunately in the introduction biological reversion is defined: it is a "clinical method designed to define and rectify the consequences of chronic toxæmia." Still more fortunately for the bewildered reader, the characteristics by which biological reversion is identified, are mentioned in the preface and we have the reassuring statement that "its disciplines, based on Hippocratic anatomy, are sequent, measured and controllable"; moreover, "no other methods produce the same results."

Dr. Higgins is a great admirer of Sir William Willcox, but this is only fitting in one who officiates as a priest in the temple of the goddess Toxæmia. Whether he has ever heard of Weir Mitchell is not disclosed nor is there much more mention of Hippocrates. He further appreciates the work of Glenard, which is creditable; he touches upon "chiropractic" without utterly condemning "this branch of our art," which suggests that he is influenced by the precept "*In dubiis, libertas, in omnibus caritas.*" Visceroptosis and lymphatic obstruction, focal sepsis and intestinal stasis are discussed. Generally speaking Dr. Higgins gives us the impression of one who prefers to treat patients given up by other doctors.

Seeing that he is a Cambridge graduate in Arts, we are not surprised to find evidence of wide reading and the work is interspersed with poetic quotations and with anecdotes, some of which, like "the flowers that bloom in the spring, tra-la," have apparently but little to do with the case. Dr. Higgins can quote Celsus and Bacon, Pascal and Chaucer and he fearlessly introduces us to the intriguing dispute as to the respective merits of poltophagy and psomophagy.

The book is well got up, although it has no index. One redeeming point is that there is no foreword by either Sir W. Arbuthnot Lane or Mr. Ellis Barker. It is dedicated to the late General Leonard Wood, United States of America, and to Sir William Willcox.

We close it with a sigh of relief and wonder whether it is not in itself a strong argument in favour of a censorship of medical literature.

PHYSICAL THERAPY.

IN the introduction to his book "On Prescribing Physical Treatment," Dr. Ray states that it is written entirely from the standpoint of the prescriber and is not intended to be in the nature of a technical hand book.[1] Judged from this standpoint the work is disappointing, as so much elementary matter is introduced. The inclusion of so much detail and the very frequent repetition of indications for treatment serve to enlarge the book far beyond the compass of a work designed entirely for the prescriber who should have a complete knowledge of the elements of his work before attempting to prescribe. With these reservations several sections of the book are exceedingly well written. We refer particularly to the section devoted to physiological considerations, immediate reactions to stimuli and secondary reactions to stimuli and would have welcomed a larger amount of information on these very essential considerations in such treatment. The space devoted to these subjects covers only twelve pages, whereas the elementary physics underlying modern methods of electrical treatment covers a space of almost forty pages. The section devoted to baths covers fifty-six pages and contains many instances of wearisome repetition. The impression gained from reading the author's description of medicated baths could be summed up in his own sentence that "the thermal qualities of mineral water baths are of more importance than their degree of mineralization." The section on massage likewise contains many elementary principles with which the prescriber should already be conversant. The seven pages might have been devoted to better advantage to a discussion of the practical applications of this method of treatment. There are many minor misprints which no doubt will be corrected in a later edition. The illustrations, apparently from photographs, are good. The reader is left with a feeling of disappointment that the later pages of the book do not fulfil the promise displayed in the excellent preliminary chapter.

[1] "The Conquest of Cancer by Radium and Other Methods," by Daniel Thomas Quigley, M.D., F.A.C.S.; 1929. Philadelphia: F. A. Davis Company. Royal 8vo., pp. 560, with illustrations. Price: $6.00 net.

[2] "Biological Reversion and Hippocratic Anatomy," by Hubert Higgins, M.A. (Cantab.), M.R.C.S. (England), L.R.C.P.; 1929. London: H. K. Lewis and Company, Limited. Demy 8vo., pp. 159. Price: 7s. 6d. net.

[1] "On Prescribing Physical Treatment," by Matthew B. Ray, D.S.O., M.D. (Edinburgh); 1929. London: William Heinemann (Medical Books), Limited. Demy 8vo., pp. 190, with illustrations. Price: 10s. 6d. net.

The Medical Journal of Australia

SATURDAY, DECEMBER 28, 1929.

Today and Tomorrow.

IN the turmoil and scurry of modern life men usually have no time to consider the position in which they stand and the changes that time is wringing on humanity. There are occasions, however, when sentiment gains the upper hand for the moment, when self becomes less important than the well-being and happiness of others and when the story of Dickens's "Christmas Carol" is reenacted in modified form in almost every establishment. As the year 1929 draws to a close we would turn to our readers with a softer message than the admonitions concerning dichotomy and other ethical offences, than diatribes concerning commercialism in professional life, than discussions on the medical curriculum. We dare on this occasion to remember that they are men and women as well as medical practitioners and wish them happiness and good health in the coming year and bid them spare a few minutes for the quiet enjoyment of human affairs and of family life. The close of the year reminds us of those who have passed away during the preceding twelve months, regretted, revered and not forgotten. Many have left a legacy to medicine, many have perpetuated their names in some advancement of knowledge, many have set a wholesome example in disinterested and unselfish endeavour to serve their contemporaries. But in addition to all this not a few of our old friends stirred in our hearts a feeling of deep affection while they moved among us and that feeling should be cherished and nurtured as a most precious possession.

The past has been replete with efforts and failures, bold advances and depressing retracings of false footsteps, tasks begun and left unfinished and a rare triumph in having progressed a very little distance. The past contains many encouraging messages and safe indications; there are prominent milestones on which the inscriptions are indelible. In the great search for truth and happiness men have discovered much of value in the past and it becomes our duty and our delight to recognize these treasures and to keep them fresh in our memories.

The present seems less clear to us than the past. We realize that times are changing, that what we believed a few years ago may be untrue and unreliable, that certainty is giving place to doubt. We seem to be better able to judge men who lived in a past generation, than those with whom we come in daily contact. Those who have reached mature years, are required to make room for the younger, more virile and more imaginative members. If no thought be given for the future, the present is apt to confuse, to mislead and to paralyse. Just as men and women can find happiness in dwelling on the memories of the past and can find comfort in the anticipation of the unknown future, so in the more serious, if not the more earnest aspects of life meditation on the teachings of former times, associated with a healthy speculation, will prepare us well for our struggles to conquer ignorance and to find the truth.

It has become habitual for men in prominent positions to discourse on the wonderful achievements of the past, especially in the world of medicine which includes surgery. It is easy to be satisfied with the infinitesimal progress that has been registered and to magnify man's doings into feats of gods. Would it not be better to be somewhat humbler, to admit that we know but little and that we need to sink all personal jealousies, to avoid the selfish forms of competition and to join hands in a supreme effort to know and to win. There are indications of many changes in the doctrines preached in the realm of medicine in the near future. The reactionary and the omniscient may awaken one day to find themselves outdistanced by the sceptical and the liberal. There is a need for good fellowship, for coordination of effort, for tolerance. We plead for the exercise of these three qualities.

Current Comment.

SYPHILIS AND PREGNANCY.

ACCORDING to the most modern teaching antenatal supervision and care include the elimination of infective disease from the mother and from the fœtus, so that the former may be able to progress to full term and, being delivered of her child, may continue in the same or better health than she enjoyed when she became pregnant and so that the latter may start on its extrauterine journey as a healthy individual. In many centres this antenatal supervision is well and carefully carried out, but in many places a curious point of view is adopted in regard to syphilis. When stigmata of syphilis are found in the mother or when there is reason to believe that the father of the child may harbour the *Spirochæta pallida*, a Wassermann test is carried out. It is, of course, well known that syphilis may be present in the mother without foci of infection being evident on her body and also that according to Colles's law a child of a syphilitic father is supposed to render its mother immune to syphilis. Although the only way in which syphilitic infection may be discovered and treated is by the routine application of the Wassermann test (this statement is made with certain reservations) to the mother's blood and to the placental blood, this routine is not generally adopted. In some places it has been attempted and its use discontinued.

In these circumstances it will be interesting and profitable to consider a report recently made by Dr. A. Simpson Wells.[1] Wells writes from South Africa where he has had charge of a large number of coloured women in a home. Since 1921 all the patients who appeared at the antenatal clinics of the home and who booked for admission to the home, have been subjected to the Wassermann test and since 1925 the placental blood has also been tested. One thousand tests were carried out on expectant mothers and only 150 of the women were married. The blood from the placenta was examined in 399 instances. Among the thousand women 282 or 28·2% gave a reaction and of the specimens of placental blood 82 or 20·5% gave a reaction. Wells states that the significance of a reaction in the placental blood is not clear and that the value of such a test has not been established. He adds that it is thought that owing to the action of the chorionic ferments a fully developed placenta has the power of preventing infection and that this is the reason why healthy children may be borne to mothers infected late in pregnancy. In view of this he looks upon his percentage of 20·5 for the blood of the placental cord as high. He has made an analysis of 77 of the cases in which the placental blood gave a reaction. Thirty-two of the mothers had received treatment, twenty-three of the mothers gave no response to the Wassermann test and twenty three of the mothers had had no treatment and had been admitted to hospital in emergency. Six of the fœtuses whose placentæ yielded blood which did not react to the test, manifested symptoms of syphilis in the first month of life.

The first thing to be noted about the figures given by Wells is the high percentages. He notes this himself and contrasts his figures with those of other observers. His patients were drawn from a coloured population and the fact that only 15% of them were married is another indication that the figures would not be comparable with those of an English-speaking white community. Wells refers among others to figures quoted by F. J. Browne in *The British Medical Journal* of August 13, 1927. Browne reported that a reaction to the Wassermann test was obtained in 6·5% of two thousand consecutive patients examined. The reaction was a strong one in 3·6%, in 0·3% it was moderately strong, in 1·4% it was a weak reaction and in 0·8% the response was doubtful. In 0·3% the serum was anticomplementary and in 0·7% there was no reaction, but the patients were regarded as syphilitic on account of other evidence. Browne concluded that in an ordinary antenatal clinic the frequency of syphilis is at most about 7%. These figures are very similar to those published in this journal in 1921 by R. Fowler who found that the incidence among 705 patients at the Melbourne Hospital was 7·5%.

Most of the difficulties of understanding the apparent anomalies of the figures reported by Wells disappear if it is remembered that while a strong response to the Wassermann test must be regarded as evidence of syphilis, failure to react does not necessarily mean that the patient is free from the disease. It must be presumed that when the blood of the placenta yields a reaction to the test, the virus is present in the fœtus and the fœtus is suffering from syphilis, though the external manifestations may not have appeared. That absence of reaction in the placental blood does not mean that the fœtus is free from infection, is shown by the fact, already mentioned, that in six instances the infants manifested symptoms of syphilis during the first month, when no reaction had been obtained in the placental blood. Treatment may alter the power of the blood to react and yet be insufficient to produce cure. It may also be asked whether it is not possible that the serum may react after the last spirochæte has been killed.

Thirty-three of the mothers had received treatment and yet the placental blood gave a reaction. Treatment in these instances cannot have been adequate and there is no statement as to the response of the blood of these mothers. It is quite conceivable that when a woman is infected with syphilis during pregnancy, the treatment may be sufficient to do away with the positive response in the maternal blood but not in the placental blood. When the mothers failed to yield a reaction, as in twenty-three instances, and yet the placental blood gave a reaction, it is possible to conclude that they come

[1] *The Journal of the Medical Association of South Africa (British Medical Association)*, June 22, 1929.

within the range of Coles's law and are immune. The modern view in regard to Coles's law, however, is that the mother is infected but that her infection is latent. This is one possibility. Another is that the mother has an old infection which has led to an attempt at spontaneous cure. Again, the absence of antibody to lipoid (lecithin, heart muscle, embryonic tissue, syphilitic or normal liver) does not indicate immunity any more than it excludes syphilitic infection. The reaction is not an antigen-antibody reaction to the syphilitic virus. The view, previously mentioned, that the mother is immune, the immunity being acquired or natural, is improbable.

From the figures quoted above it is clear, if indeed proof were needed, that use of the Wassermann test will reveal an infection in a large percentage of women and fœtuses. There can then be no argument against its adoption as a routine in all public hospitals. When once this has been achieved, the logical corollary will follow, namely the use of the test in all pregnancies. In the home described by Wells the test was first adopted as a routine for all patients in the antenatal department who were to be admitted. This is a convenient manner in which this work may be started in any institution where the practice does not obtain. Objections may come from the patient if all details of the reason for the test are given to her. There is no necessity to go into too detailed an explanation. If there are objections to the drawing off of blood from a vein before the actual confinement, there can be none to the collection of blood from the placental vessels. It is true that in certain instances valuable time may have been wasted because the test was not done earlier, but it would be better to carry out the test at this stage than to neglect it altogether. There can be no valid objection on the part of the medical practitioner. Admittedly the test does not reveal every infection, but it will reveal many of them and every point gained in the struggle against syphilis is one in favour of ultimate victory.

British Medical Association News.

ANNUAL MEETING.

THE ANNUAL MEETING OF THE QUEENSLAND BRANCH OF THE BRITISH MEDICAL ASSOCIATION was held at the B.M.A. Rooms, Adelaide Street, Brisbane, on December 13, 1929, DR. MERVYN PATTERSON, the President, in the chair.

ANNUAL REPORT OF COUNCIL.

The annual report of the Council was taken as read and adopted on the motion of Dr. Alex Murphy, seconded by Dr. Hope Michôd.

The Honorary Treasurer presented the financial statements which were adopted (see pages 929, 930).

THE Council has pleasure in presenting the following report of the work of the Branch for the year ended November 15, 1929.

Membership.

The membership of the Branch which was 460 at the end of last year, has increased to 475, which shows a net gain of 15.

The additions have been: Elections of new members 10, transferred from other Branches 27, reinstated 4, rejoined 2. The losses have been: Transferred to other Branches 18, resigned 3, unfinancial 3, deceased 4.

The Council regrets to record the deaths of the following members: Dr. G. W. S. Farmer, Maryborough, Dr. J. N. Woodhead, Brisbane, Dr. Reginald Freshney, Toowoomba, Dr. J. W. G. Powell, Ingham.

Meetings.

General.

The annual meeting and ten ordinary meetings of the Branch were held during the year, including two clinical meetings. Two extraordinary meetings were held as follows: February 14, *re* the inauguration of a contract practice section; November 6, Professor E. J. Goddard, of the University of Queensland, delivered a lecture on the question of a medical school for Brisbane. The average attendance at these meetings was 48.

Council.

The Council held twenty-one ordinary meetings and three special meetings. The special meetings were held to consider matters in connexion with the lodge question.

Dr. Eustace Russell who is abroad, was granted leave of absence in February last. In March Dr. A. T. Nisbet resigned from the Council owing to his departure from the State and Dr. J. Hedley Brown was appointed in his stead. Dr. E. Sandford Jackson resigned his position on the Council in July, Dr. Clif. Tucker being appointed to fill the vacancy. Dr. Alex. Murphy was appointed Chairman of Committees.

The record of attendance of members of the Council was as follows:

	Ordinary.	Special.
Dr. Mervyn Patterson (President) ..	19	2
Dr. S. F. McDonald (President-Elect) ..	18	3
Dr. Eustace Russell[1] (Past President)	3	—
Dr. B. L. W. Clarke (Honorary Secretary)	20	3
Dr. F. A. Hope Michôd (Honorary Treasurer)	18	3
Dr. N. W. Markwell (Assistant Honorary Secretary)	20	3
Dr. Alex. Murphy (Chairman of Committees)	19	3
Dr. Neville G. Sutton (Honorary Librarian)	17	1
Dr. M. Graham Sutton (Honorary Curator of Museum)	16	2
Dr. E. S. Meyers[2] (Federal Committee Representative)	17	2
Dr. D. Gifford Croll[2] (Federal Committee Representative)	19	1
Dr. Hedley J. Brown[3] (Councillor) ..	13	1
Dr. H. V. Foxton (Councillor)	13	1
Dr. E. Sandford Jackson (Councillor, resigned)	8	1
Dr. C. M. Lilley (Councillor)	19	1
Dr. A. T. Nisbet (Councillor, resigned)	4	—
Dr. L. J. Jarvis Nye (Councillor) ..	18	—
Dr. W. N. Robertson (Councillor) ..	11	2
Dr. D. E. Trumpy[4] (Councillor)	14	—
Dr. Clif. Tucker[5] (Councillor)	7	—

Scientific Meetings.

February.—Clinical meeting, Brisbane Hospital, combined with Brisbane Hospital Clinical Society.

[1] On leave.
[2] Absence due to Federal Committee meetings.
[3] Elected March.
[4] On leave through illness.
[5] Elected July.

March.—Dr. D. Gifford Croll: "The Incidence of Chronic Nephritis in Young Persons in Queensland."
Dr. L. J. Jarvis Nye: "The Pathogenesis of Chronic Nephritis in Young Persons in Queensland."
April.—Dr. L. M. McKillop: "Modern Aspects of the Cancer Problem," illustrated by cinematograph film (Canti cancer film).
May.—Bancroft Memorial Lecture: "Diseases of the Pituitary Gland," illustrated by lantern slides.
June.—Dr. Ellis Murphy: "Some Aspects of Post-Graduate Work in London."
July.—Dr. J. J. Power: "Some Notes of a Recent Study of Urology in America."
August.—Dr. Arthur Murphy: "Deafness in General Practice."
September.—Sir Ewen Maclean: Address on matters of general interest.
October.—Clinical meeting, Mater Misericordiæ Public Hospital, combined with Mater Misericordiæ Public Hospital Clinical Society.
November.—Dr. Keith C. Ross: "Hæmorrhage in Peptic Ulceration."
November 6.—Special meeting: Paper by Professor E. J. Goddard on "The Necessity for the Establishment of Medical Research Bureaux and the Need for a Medical School in Brisbane."

The Committee responsible for the programme of papers consisted of Dr. C. M. Lilley, Dr. L. J. J. Nye and Dr. N. W. Markwell. Mr. George Hancox is the Honorary Lanternist of the Branch and the thanks of the Council are extended to him for his services.

Library.

Owing to lack of space, the library is mainly devoted to keeping up periodicals which it is considered are most useful to the majority of members.

At present old books are being removed from the shelves for storage until there is more space available, in order to make room for the increasing number of bound journals.

A number of members who borrow books from the library, keep them far beyond the period specified in the rules, which means that other members are debarred from making use of such books at the time when they require to refer to them.

Our thanks are due to Dr. A. C. F. Halford for presenting a copy of his book, "Lister Redivivus," to the Branch library and also for a copy of a clinical lecture on antiseptic surgery by Lister. The executors of the estate of the late Mrs. W. S. Byrne presented the Branch with four framed pictures of old medical groups.

Photographs of Past Presidents.—We have now thirty-one photographs of past Presidents of the Branch and of the old Queensland Medical Societies.

Museum.

The museum specimens still continue to be housed at the Pathological Department of the Brisbane and South Coast Hospitals Board.

Federal Committee.

As usual, two meetings of the Federal Committee were held at which the Branch was represented by Dr. D. Gifford Croll and Dr. E. S. Meyers. Reports of the proceedings were published in THE MEDICAL JOURNAL OF AUSTRALIA.

During the year the Association has suffered a severe loss in the untimely death of Sir G. A. Syme who was for many years Chairman of the Federal Committee.

Australasian Medical Congress.

The third session of the Australasian Medical Congress (British Medical Association) was held in Sydney in September last and was an unqualified success from every point of view. Those who were responsible are to be highly congratulated on the efficient organization, both from a scientific and a social aspect. The Queensland members who joined congress, numbered fifty-seven. Dr. E. S. Meyers acted as Honorary Local Secretary for the State.

Representation.

The Branch was represented as follows:
Council of the British Medical Association: Sir T. Jenner Verrall, LL.D. (now deceased).
Representative Body: Dr. Eustace Russell.
Annual Meeting of the British Medical Association, Manchester, 1929: Dr. A. Breinl, Dr. C. F. A. de Monchaux.
Federal Committee of the British Medical Association in Australia: Dr. D. Gifford Croll and Dr. E. S. Meyers.
Australasian Medical Publishing Company, Limited: Dr. D. Gifford Croll, Sir David Hardie, M.D., and Dr. J. Lockhart Gibson. Dr. Croll was appointed a Director of the company during the year owing to the resignation of Dr. W. N. Robertson.
Bush Nursing Association Council: Dr. N. W. Markwell.
Queensland Medical Land Investment Company, Limited: Dr. F. A. Hope Michôd.
Queensland Cancer Trust: Dr. B. L. W. Clarke and Dr. Val. McDowall.
North-eastern Medical Association, New South Wales, Annual Meeting, Lismore, April: Dr. F. A. Hope Michôd who read a paper by invitation.
Reception to the Delegation from the Order from Saint John of Jerusalem: Dr. S. F. McDonald and Dr. B. L. W. Clarke.
Conference on Unemployment: Dr. E. S. Meyers.
Memorial Meeting, Late Sir G. A. Syme: The Branch was represented by Dr. R. Marshall Allan, at the request of the Council, at the memorial meeting held by the Victorian Branch on May 13 to the late Sir G. A. Syme.

Subcommittees.

Hospital.

Personnel: Dr. E. S. Meyers, Dr. C. M. Lilley and Dr. C. E. Tucker and *ex officio* members.

The hospital position is in much the same state as it was last year. The Council has done a great deal of work to pave the way for an improvement on the old conditions. As usual, the affairs of country hospitals have taken up a considerable amount of time.

Shortly after the new government came into office, a deputation from the Council placed before the Premier and other members of the Cabinet certain facts and suggestions that had been prepared by the subcommittee. The deputation received a very sympathetic hearing and the Premier promised that a Royal commission on hospital matters would be appointed and that the scope of the commission would be wide enough to enable consideration to be given to the many points raised by the Queensland Branch of the British Medical Association. In drawing up the report for the deputation the subcommittee has specially kept in mind various points brought forward by different medical practitioners. As soon as the commission has been appointed and the scope of the commission made known, the subcommittee will no doubt get into touch with country members with a view to obtaining further information and suggestions from them upon such matters as contributory schemes, maternity service *et cetera*.

The whole hospital question hinges upon the findings of the Royal commission and all matters connected therewith must of necessity remain in abeyance until the commission's report is published.

Members of the Branch undertaking hospital work are again warned that they should in all cases submit copies of agreements to the Council when they apply for hospital positions. In their own interests, immediately they make application for such positions, they should ask to be supplied with a written agreement between the medical officer and the hospital committee. If this is done, they will be in a position to know the conditions under which they will be working. As it is at present, many medical officers of hospitals receive disillusionment after they find themselves in a position from which they would gladly escape, and in many cases such escape is only possible at a financial sacrifice.

Infectious Diseases Hospital, Brisbane.—At a combined meeting with the Public Health Subcommittee the plans of

the Infectious Diseases Hospital at present being erected by the Brisbane City Council, were criticized and subsequently altered in accordance with the suggestions made.

Rules and Ethical.

Personnel: Dr. L. J. J. Nye, Dr. N. W. Markwell and Dr. Hedley J. Brown.

Amendment of By-Laws.—Contract Attendance, Friendly Society Lodges: At a general meeting of the Branch held on June 7, 1929, the following by-laws were repealed: (*a*), (*b*) (i) and (ii), (*c*), (*e*) (*g*) and (*h*) (*vide* page 41, By-Laws of the Branch) and various clauses substituted therefor which have been circulated to members, this being the only alteration in the by-laws during the year.

Ethical.—Model Rules Governing Procedure in Ethical Matters: Recommendations regarding these model rules were drawn up by the subcommittee for submission to the Federal Committee. These rules have been adopted by the Federal Committee, but as some of them are not in accord with the Articles of Association of this Branch and as we have our own by-laws for dealing with such matters, no further steps have been taken by the Council in the matter.

Adjudicating at Baby Shows: The Council disapproves of the principle of members acting as judges in baby shows.

A number of personal ethical questions have been dealt with on behalf of members.

Public Health.

Personnel: Dr. S. F. McDonald and Dr. D. Gifford Croll.

Infectious Diseases Hospital: The plans of the Infectious Diseases Hospital at present being erected by the Greater Brisbane Council, were criticized by the Hospital and Public Health Subcommittees combined and a number of alterations were suggested, notably the position of the diphtheria ward. A subsequent conference was held between representatives of the Public Health Committee and the City Council and alterations were carried out in accordance with the suggestions that were made.

Pneumonic Influenza: Representatives of the subcommittee had a conference with the Town Clerk and a communication was sent suggesting that a conference be held with the City Medical Officer of Health which, however, was never arranged.

"Insulin": The question of "Insulin" was referred to the Branch by the Commissioner of Public Health for comment regarding its removal from the list of poisons. It was recommended that it should remain on the list of poisonous drugs to be dispensed only by prescription.

"Atophan": At the request of the Commissioner of Public Health for an expression of opinion, members were circularized as to whether any ill effect had resulted from the use of this drug. No affirmative replies were received.

Building.

Personnel: Dr. W. N. Robertson, Dr. D. Gifford Croll, Dr. L. J. J. Nye, Dr. F. A. Hope Michôd.

No steps have been taken to erect new premises for the Branch at Wickham Terrace, as the time is not considered opportune to dispose of the Adelaide Street property. "Bay View," the Wickham Terrace property, is still occupied by a tenant whose lease expires in March next.

Parliamentary.

Personnel: Dr. W. N. Robertson, Dr. H. V. Foxton, Dr. L. J. J. Nye and Dr. Hedley J. Brown.

This subcommittee was appointed to watch the interests of the profession in relation to new acts and amendments of acts which may affect it.

Post-Graduate Course.

Personnel: Dr. A. G. Anderson, Dr. E. D. Ahern, Dr. Ellis Murphy, Dr. D. Gifford Croll, Dr. Val. McDowall, Dr. D. A. Cameron, Dr. J. V. Duhig, Dr. M. Graham Sutton, Dr. H. S. McLelland, Dr. Alan E. Lee, Dr. Alex. Murphy, Dr. E. S. Meyers, Dr. Clif. Tucker, Dr. G. A. C. Douglas, Dr. L. M. McKillop. Dr. S. F. McDonald and Dr. Neville G. Sutton, Joint Honorary Secretaries.

This subcommittee has again to report a very successful year. The annual course this year, owing to congress, was held in May. This innovation of holding the course earlier has proved to have many advantages and will be adopted in future.

The course opened with a most instructive demonstration in practical orthopædics by Dr. A. V. Meehan, dealing with the correction of deformities. It was well attended and most appreciated.

In addition to delivering the Bancroft Oration, Dr. (now Sir Richard) Stawell, of Melbourne, very kindly arrived in Brisbane early in the week and gave two additional afternoons, one a lecture on the "Early Diagnosis of Pulmonary Tuberculosis" and a clinical demonstration of diseases of the nervous system. Both were well attended.

Dr. C. E. Corlette who came from Sydney to deliver the surgical lectures, lectured on local anæsthesia and on fractures and performed surgical operations at both the Brisbane and the Mater Misericordiæ Public Hospitals.

Dr. E. H. Molesworth and Dr. H. M. Moran, of Sydney, also came to Brisbane and gave lectures and demonstrations on the treatment of malignant disease by radiation.

All the lectures and demonstrations were well attended and the course was thoroughly successful, both from the scientific and the financial aspects.

The subcommittee hopes to launch still further in the coming year. The course will be held in the first week in June and so far Dr. S. V. Sewell and Mr. W. S. Newton, of Melbourne, will be lecturing.

It had been hoped that Professor Findlay, of Glasgow, who is to be in Melbourne in September next, might be induced to come to Queensland, but this has not been possible owing to the shortness of his stay in Australia.

The subcommittee intends next year to arrange a series of lectures for the local associations by members from Brisbane. Several local associations have accepted the suggestion with enthusiasm and it only remains for details to be worked out.

Sections for Special Branches of Medical Knowledge.

Eye, Ear, Nose and Throat Section.

Inaugurated 1924.

President, Dr. W. N. Robertson; Vice-President, Dr. E. O. Marks; Councillor, Dr. E. Culpin; Honorary Secretary, Dr. Walter Lockhart Gibson.

The number of members of the section is twenty-two.

Three quarterly meetings, one annual meeting and one special meeting have been held during the year.

Surgical Section.

Inaugurated February, 1927.

President, Dr. A. V. Meehan; Honorary Secretary and Treasurer, Dr. M. Geaney; Committee, Dr. E. S. Meyers, Dr. H. S. McLelland and Dr. M. Graham Sutton.

Membership, seventeen financial members.

Meetings.—There were three meetings of the Section held during the year, the papers read being "Treatment of Fractures of the Lower Limb," by Dr. G. A. C. Douglas, "Technique in the Surgical Treatment of Exophthalmic Goitre," by Dr. R. Graham Brown, "Technique in the Surgical Treatment of *Prolapsus Uteri*," by Dr. J. Cameron Hemsley. All the papers were of a very high standard and were greatly appreciated. One outstanding feature of these papers was the fact that they were absolutely practical, each contributor giving us the benefit of his experience in the work he was doing.

Obstetric Section.

Inaugurated November 15, 1927.

President for 1929, Dr. Alex H. Marks; Vice-Presidents, Dr. D. Gifford Croll and Dr. F. A. Hope Michôd; Honorary Treasurer, Dr. Hedley J. Brown; Honorary Secretary, Dr. L. H. Foote; Statistical Committee, Dr. F. A. Hope Michôd, Dr. H. S. Waters, Dr. R. G. Quinn and Dr. L. H. Foote.

This is the second year of the section's activities, the objects of which are to improve the obstetrical practice of members and to compile a reliable set of statistics from the records of private practice for comparison with those available from hospitals (public).

The annual meeting was combined with the first quarterly meeting held in January, at which office-bearers were elected for the ensuing year. At this meeting it was decided to hold the annual meeting for elections in February.

Quarterly meetings were held in January, April, July and October, the average attendance being twenty-two, at which statistics for each quarter were presented and all cases of interest reported and discussed. These cases included concealed accidental hæmorrhage (death), eclampsia, renal disease in pregnancy, breech cases, prolapse cord, paper and slides on acute yellow atrophy of liver by Dr. Michôd and Dr. Duhig, *placenta prævia*, Cæsarean section.

At the October meeting statistics of the first thousand cases reported by members of the section were reported.

A special meeting was held in September to meet Dame Janet Campbell to discuss and hear her views on maternal and infant mortality and morbidity.

Medical Section.

Inaugurated June 1, 1928.

President, Dr. Eustace Russell; Honorary Secretary, Dr. T. H. R. Mathewson; Members of Committee, Dr. J. V. Duhig, Dr. S. F. McDonald, Dr. L. J. J. Nye.

Membership, thirty.

Four meetings of the Medical Section were held during the year at which the following papers were read:

February: "Primary Cancer of the Lung," by Dr. Ellis Murphy.

May: "Meningitis," an account of patients suffering from meningitis treated at the Hospital for Sick Children, Brisbane, during the past seven years by Dr. Alec Paterson. An investigation into the bacteriology of meningitis based on these cases, by Dr. J. V. Duhig.

August: "The Treatment of *Diabetes Mellitus*," by Dr. Cyril Shellshear.

November: "Methods in Psycho-Therapy," by Professor J. P. Lowson.

Contract Practice Section.

This section was inaugurated on February 14, 1929, when the following office-bearers were elected: President, Dr. A. B. Carvosso; Honorary Treasurer, Dr. J. L. Selwood; Honorary Secretary, Dr. Clif. Tucker; Committee representing various districts in the metropolitan area: South Brisbane, Dr. M. Graham Sutton; Coorparoo, Dr. L. W. Gall; Sherwood, Dr. F. G. Meade; North Brisbane, Dr. Gavin Cameron; Red Hill and Paddington, Dr. D. V. Sheil; Windsor, Kedron and Enoggera, Dr. H. S. Waters; Sandgate and Northgate, Dr. L. J. Dart; coopted member, Dr. E. S. Meyers.

This Contract Practice Section executive has taken the place of the former special lodge subcommittee. Fortnightly meetings are held and reports are made to the Council. This executive is also dealing with the question of national medical insurance.

The year has been one of steady development of lodge contract practice in the metropolitan area, through the medium of the Friendly Societies Medical and Hospital Council and in the country. All the orders have become reconciled to the Council and to the terms of the Federal model lodge agreement.

During the last twelve months the numbers handled by the Council have increased from 5,000 to 13,000. It is now only a matter of time before the few irregular practitioners, not members of the Branch, doing lodge contract practice under terms not sanctioned by the Branch, will be forced to consider their position.

The Friendly Societies Medical and Hospital Council report the satisfaction of their members at the medical service given by members of the Branch. All differences will be minimized if our members will make themselves thoroughly conversant with the terms of the service and by a liberal interpretation of their clauses, thus engendering the spirit of goodwill on which the steady growth and progress of this practice is so dependent. Members are reminded that after many years we have been able to build up a contract service reasonable and fair to all parties and the obligation rests with our members to make it an indispensable service to the community.

With the assistance and cooperation of the country members the model lodge agreement has, with few exceptions, been introduced throughout Queensland.

In certain towns and districts the hospital contributing schemes and the lodge contract service have come so much into conflict that the matter has been held in abeyance pending the hospital commission dealing with it. During the year an interstate contract practice conference was held to consider contract practice and national insurance from a Federal aspect. A common basis of action was agreed upon and the foundation laid for a Federal body to be formed to deal with all aspects of contract practice.

During the year throughout Queensland an important principle has been striven for, *videlicit* the open list, so that membership of the Branch will automatically carry with it the right to engage in contract practice if a member so wishes.

Numerous attempts have been made to draw up a schedule of contract prices for operations for lodge patients. The *questionnaire* now before the members, if answered, will greatly help the section in submitting such a schedule to the Council.

Medical Practitioners' Emergency Fund.—In view of the fact that there did not appear to be any likelihood of calls being made on this fund, it was decided by the Council to refund the amounts so generously donated to the members concerned.

Affiliated Local Associations.

Downs and South-Western (Toowoomba).—The work of the Association has been filled in chiefly in dealing with two matters, the finalization of the group system which has been satisfactorily completed and should prove of assistance to other districts when their turn comes, in that it will form some basis for negotiation. The other matter has been the introduction of the model lodge agreement. This, with the great help received from headquarters, has been successfully introduced in all centres with the exception of Toowoomba, where it is certain it will be accepted before the end of the year.

The association will for the following twelve months be under the guidance of Dr. T. A. Price, Toowoomba, with Dr. J. S. Smyth, Warwick, and Dr. A. D. McKenzie, Toowoomba, as Vice-President. The Honorary Secretary and Treasurer is Dr. Spencer Roberts, Toowoomba.

It is expected that more clinical work will be undertaken during the year, more especially as the parent Branch is considering the advisability of sending experienced men to outside centres to assist at such meetings.

West Moreton (Ipswich).—One ordinary and two special meetings of the association have been held. The special meetings were held to discuss the model lodge agreement and the question of uniformity of fees and on June 21, 1929, the amended agreements between the lodges and the members of the association were signed by both parties and copies were forwarded to the Queensland Branch headquarters.

The President of the local association is Dr. J. A. Cameron and Dr. T. J. Flynn is Honorary Secretary. Membership is nineteen.

Central Western (Longreach).—One meeting of the members was held in Barcaldine on February 4. This was very well attended and a lengthy discussion of the Federal model lodge agreement was held. The resolutions at this meeting have been forwarded to the Council. The approval of the Council has been given to them and as far as can be ascertained the lodge practices are being carried out under the terms of the agreement to the satisfaction of all parties.

Owing to the impossibility of meetings being arranged no office-bearers have been appointed for this area, but the members are keenly interested in all association matters.

Townsville.—Honorary Secretary, Dr. L. P. Brent. Membership, seventeen. Six meetings have been held in the course of the year at which papers were read by various members. During the year the members were addressed by Dr. Burrows on radium treatment of cancer

QUEENSLAND BRANCH OF THE BRITISH MEDICAL ASSOCIATION (INCORPORATED).

Balance Sheet as at November 15, 1929.

LIABILITIES.	£ s. d.	£ s. d.
British Medical Association, London		47 3 6
Australasian Medical Publishing Company, Limited		47 10 0
English, Scottish and Australian Bank, Limited, Brisbane—Overdraft, Building Fund Account	1,329 17 7	
Interest Accrued to November 15, 1929	17 9 7	
		1,347 7 2
Loans from Members, repayable May 15, 1943	5,035 0 0	
Interest Accrued to November 15, 1929	176 5 8	
		5,211 5 8
Sundry Creditors		37 16 0
Annual Dinner Account		10 19 3
Accumulation Account		873 18 9
		£7,576 0 4

ASSETS.	£ s. d.	£ s. d.
B.M.A. Rooms, Adelaide Street, Brisbane—Library, Book Cases, Furniture, Lantern, Typewriter *et cetera*		312 0 0
Museum Specimens		5 0 0
Queensland Medical Land Investment Company, Limited—4,625 Shares of £1 each, paid up to 10s. each, at cost		2,312 10 0
Freehold Property, "Bayview," Wickham Terrace, Brisbane—Land, area 31¾ perches	1,500 0 0	
Improvements, Two-storied wood Residential Building (less depreciation to November 15, 1929, at 5% *per annum*)	2,294 0 0	
		3,794 0 0
Furniture in "Bayview" (less Depreciation to November 15, 1929, at 10% *per annum*)		419 0 0
Australasian Medical Publishing Company, Limited, Sydney—Two Debentures of £25 each		50 0 0
Unused Stationery Coupons		13 0 0
Sundry Debtors		30 10 0
English, Scottish and Australian Bank, Limited, Brisbane—Credit Balance, General Fund Account		636 6 2
Cash in Hand		3 14 2
		£7,576 0 4

I have examined the above Balance Sheet and have obtained all the information and explanations I have required. In my opinion the balance sheet is properly drawn up so as to exhibit a true and correct view of the state of the Association's affairs as at November 15, 1929, according to the best of the information and explanations given me, and as shown by the books of the Association.

F. A. HOPE MICHÔD,
Hon. Treasurer.

ROY G. GROOM, Chartered Accountant (Aust.),
Auditor.

Brisbane.
November 22, 1929.

QUEENSLAND BRANCH OF THE BRITISH MEDICAL ASSOCIATION (INCORPORATED).

Building Fund Statement of Receipts and Payments for Twelve Months ended November 15, 1929.

RECEIPTS.	£ s. d.
November 16, 1928.	
To Commonwealth Savings Bank of Australia, Credit Balance	643 16 3
November 15, 1929.	
To Loans from Members for Period to Expire May 15, 1943, carrying Interest at 7% *per annum*, payable on May 15 in each year	35 0 0
„ Rents from "Bayview," Wickham Terrace	442 0 0
„ Queensland Medical Land Investment Company, Limited—Dividend 12 months ended November 25, 1928	136 13 0
„ Commonwealth Savings Bank Interest	11 6 3
„ English, Scottish and Australian Bank, Limited, Brisbane—Debit Balance	1,329 17 7
	£2,598 13 1

PAYMENTS.	£ s. d.
November 15, 1929.	
By Balance, Purchase Money, "Bayview," Wickham Terrace	1,875 0 0
„ Purchase of Shares in Queensland Medical Land Investment Company Limited—60 Shares of £1 each, paid to 10s. each	30 0 0
„ Rates, Insurance and Repairs, "Bayview"	203 18 10
„ Interest	455 16 3
„ Sundry Expenses	33 18 0
	£2,598 13 1

QUEENSLAND BRANCH OF THE BRITISH MEDICAL ASSOCIATION (INCORPORATED).

Statement of Receipts and Payments (General Fund) for Twelve Months Ended November 15, 1929.

RECEIPTS.	£ s. d.	£ s. d.
November 16, 1928.		
To Cash at Banks and in Hand—		
National Bank of Australasia, Limited, Brisbane	173 1 1	
Commonwealth Savings Bank, Brisbane	274 9 2	
Cash in Hand	6 18 0	
		454 8 3
November 15, 1929.		
To Subscriptions—		
For Remittances to British Medical Association, London	599 10 6	
For Remittance to THE MEDICAL JOURNAL OF AUSTRALIA, Sydney	590 2 6	
Queensland Branch Subscriptions	272 11 3	
Organization Fund, Queensland Branch	741 12 0	
		2,203 16 3
Commonwealth Savings Bank —Interest on Current Account		14 9 3
„ Subscriptions to Annual Dinner Account		71 1 1
„ Sundry Receipts		11 0 0
		£2,754 14 10

PAYMENTS.	£ s. d.	£ s. d.
November 15, 1929.		
By British Medical Association, London—		
Remittances on Account of Subscriptions, 1928 and 1929		562 11 0
„ Australasian Medical Publishing Company, Limited—		
Payments for THE MEDICAL JOURNAL OF AUSTRALIA, 1928 and 1929		552 12 6
„ Library Expenditure—Books, Journals and Bookbinding		45 9 4
„ Branch Expenses—		
Office Salaries and Honorariums	374 1 4	
Printing and Stationery	108 5 6	
Electric Light	13 10 3	
Rent	52 0 0	
Cleaning	47 7 0	
Telephone	19 15 11	
Bank Charges £13 3 7		
Less Exchanges Refunded 6 8 0		
	6 15 7	
Stamps and Telegrams	50 11 6	
Audit Fees to November 15, 1928	15 15 0	
Expenses, Federal Committee	70 1 0	
Insurance — Fire, Workers' Compensation and Unemployment	3 17 3	
Legal Costs	2 2 0	
Services *re* Taxation Appeal	6 6 0	
Renewals and Repairs, Office Furnishings	11 2 3	
Balopticon Operator	2 10 0	
Federal Income Tax, 1923 and 1924 and 1925	2 1 0	
Council and General Meeting Expenses, Newspapers and Sundries	25 10 0	
Subscription, Town Planning Association	2 2 0	
		813 13 7
„ Expenses in connexion with Lodge Agreement		30 15 11
„ Annual Dinner Expenditure		60 1 10
„ Purchase of 10 Shares in Queensland Medical Land Investment Company, Limited		5 0 0
„ Purchase of Office Furniture and Fittings		44 10 4
„ Cash at English, Scottish and Australian Bank, Limited, Brisbane		636 6 2
„ Cash in Hand		3 14 2
		£2,754 14 10

and in October a lecture on the same subject with cinematograph film was delivered by Dr. L. M. McKillop and Dr. Val. McDowall.

Rockhampton.—President, Dr. R. H. Leeds; Vice-President, Dr. Trevor A. Parry; Honorary Secretary and Treasurer, Dr. J. Bruce Gordon. Membership, fourteen. Three meetings were held during the year.

Bundaberg.—Honorary Secretary, Dr. Egmont Schmidt.

Maryborough.—Honorary Secretary, Dr. W. Gilbee Brown.

Cairns.—Honorary Secretary, Dr. P. S. Clarke.

Western (Charleville).—Honorary Secretary, Dr. A. W. Fox.

Motor Car Badge for Members.

The motor car badge which was referred to in last year's report, has now been adopted and the cooperation of the Traffic Department has been obtained. In this connexion the thanks of the Council are due to the New South Wales Branch for permission to make use of their registered design.

Queensland Cancer Trust.

In July last Dr. E. Sandford Jackson tendered his resignation as a representative of the Branch on the Queensland Cancer Trust and Dr. B. L. W. Clarke was appointed in his stead. Dr. Val. McDowall is also a representative of the Branch on the Trust.

Joseph Bancroft Memorial Lecture.

The Joseph Bancroft Memorial Lecture was delivered by Dr. (now Sir Richard) Stawell, of Melbourne, on Friday, May 3, 1929, at the Geology Theatre of the University of Queensland. The subject of the lecture was "Diseases of the Pituitary Gland" (illustrated by lantern slides). There was a large attendance of members and at the conclusion of the lecture the President presented the Bancroft Memorial Medal to the lecturer.

The College of Surgeons of Australasia.

An invitation was extended to members of the Branch to be present at the lecture given by Dr. R. B. Wade, of Sydney, under the auspices of the College of Surgeons of Australasia, on Friday, November 15, on "Hirschsprung's Disease."

Social.

The annual dinner of the Branch was held on May 2 at Rowe's Banquet Hall, the attendance being over sixty. The guests of honour were His Excellency Sir John Goodwin, Sir Richard Stawell, Dr. C. E. Corlette, Dr. E. H. Molesworth and Dr. H. M. Moran.

The Branch also gave a farewell dinner to Dr. Eustace Russell prior to his departure for England, which was held in February.

Sir Ewen Maclean was entertained at dinner by the members of the Council.

Prior to the Bancroft Memorial Lecture the President entertained the members of the Council and the visitors from other States at dinner.

On Monday, April 29, a dance and bridge evening was held at Rowe's Banquet Hall in connexion with the opening of the post-graduate course. Over one hundred members and their friends were present. The arrangements were in the hands of Dr. V. N. B. Willis and Dr. M. Graham Sutton.

Congratulations.

The congratulations of the Branch were extended to Sir Richard Stawell and Sir Wm. Colin Mackenzie, of Melbourne, and Dr. the Honourable Earle Page, on honours conferred upon them. To Dr. R. Marshall Allan, on his appointment to the Chair of Obstetrics at the Melbourne University; also to Dr. P. J. Kerwin on his election as a Member of the Legislative Assembly of Queensland, and to Mr. R. C. Cowley, Registrar of the Pharmacy Board of Queensland, on his appointment as Australian member on the Board of the British Pharmacopœia.

Commonwealth Government Radium.

The late Federal Minister for Health, Sir Neville Howse, was approached with regard to the limitation being placed on the use of Commonwealth Government radium which debarred many persons from receiving treatment who were not in the public hospital class. A reply was received, however, to the effect that it is not considered advisable to make any departure from the policy adopted on the recommendation of the Advisory Committee, *videlicit* limiting the use of radium to established clinics and general hospitals.

Medical Secretary, British Medical Association.

The Branch is looking forward with pleasure to a suggested visit from Dr. Alfred Cox subsequent to 1932 after his retirement from the position as Medical Secretary, which he has held for many years. Dr. Cox has been in touch with the affairs of the Association for so long and it is felt that a visit from him would result in strengthening the bonds between the parent body and the overseas Branches and make for closer cooperation and mutual understanding.

Sir Ewen Maclean's Visit.

In September last Sir Ewen Maclean, the immediate Past President of the British Medical Association and Professor of Obstetrics at Cardiff University, paid a visit to the Branch and gave an informal address on matters of general interest, touching on questions of medical politics, national medical insurance *et cetera*. There was an excellent attendance at this meeting, ninety members being present.

Aerial Medical Officer, Australian Inland Mission.

In order to ascertain the views of members practising in the districts covered by the flying doctor as to whether the scheme had interfered with their private practice, a circular letter was sent to the medical practitioners concerned. The principle on which the Australian Inland Mission has been established, is that the flying doctor will not interfere with the practice of medical men in the area where he is working. From the replies received the scheme appears to be working satisfactorily as far as the majority of members are concerned and several suggestions which were made were forwarded on to Dr. Dunbar Hooper in Melbourne, who is the medical representative on the Board of the Australian Inland Mission. We are informed that a conference on the matter will probably be held next year.

Workers' Compensation Insurance.

The question of workers' compensation insurance, as it affects members of the Branch, is being investigated.

Fees for Medical Witnesses.

For some time past complaints have been received from members regarding the inadequacy of fees paid by the Crown Law Department in connexion with professional evidence given by medical practitioners, especially when journeys have to be undertaken to some distant centre and the engagement of a *locum tenens* is necessary. The matter has been placed before the authorities concerned and it is hoped that a satisfactory amendment of the regulations will result at an early date.

Election of Office Bearers.

The President announced the result of the election of office bearers and members of the Council.

President: Dr. S. F. McDonald.

President-Elect: Dr. F. A. Hope Michôd.

Past-President: Dr. Mervyn S. Patterson.

Honorary Secretary: Dr. B. L. W. Clarke.

Representatives on the Federal Committee: Dr. D. Gifford Croll, Dr. E. S. Meyers.

Members of the Council: Dr. Hedley J. Brown, Dr. D. Gifford Croll, Dr. Gavin H. Cameron, Dr. H. V. Foxton, Dr. C. M. Lilley, Dr. W. N. Markwell, Dr. E. S. Meyers, Dr. F. A. H. Michôd, Dr. A. P. Murphy, Dr. J. L. Nye, Dr. W. N. Robertson, Dr. Eustace Russell, Dr. M. Graham Sutton, Dr. Neville G. Sutton.

On the motion of Dr. F. A. H. Michôd, seconded by Dr. B. L. W. Clarke, Mr. Roy G. Groom was appointed auditor, the remuneration to be fixed by the Council.

President's Address.

Before vacating the chair Dr. Mervyn Patterson read an address (see page 910).

Induction of President.

Dr. Patterson then performed a pleasing duty, inducting the new President, Dr. S. F. McDonald, to the chair.

Dr. S. F. McDonald said he was grateful for his election and looked forward to a considerably lighter year than his predecessors. He referred to his desire to increase the sphere of post-graduate work.

He wished to move a vote of thanks to the retiring President, to the retiring members of Council, to Dr. Michôd and to Mrs. Spooner and Miss Milner.

The vote of thanks was accorded by acclamation.

Proceedings of the Australian Medical Boards.

NEW SOUTH WALES.

THE undermentioned have been registered under the provisions of *The Medical Act* 1912 *and* 1915, of New South Wales, as duly qualified medical practitioners:

Deane, Edward Hayden Wilcox, M.B., B.S., 1925 (Univ. Melbourne), Elsternwick, Victoria.
Engelbrecht, Mavis Stella, M.B., B.S., 1925 (Univ. Melbourne), Wagga Hospital, Wagga.
Fairley, Ronald Adrian, M.B., B.S., 1927 (Univ. Melbourne), Corowa.
Henry, Joseph Thomas, M.B., 1929 (Univ. Sydney), Sydney Hospital.
McKinnon, Malcolm Charles, M.B., B.S., 1929 (Univ. Sydney), Sydney Hospital.
Pottinger, George Wilfred, M.B., B.S., 1929 (Univ. Sydney), Saint Vincent's Hospital.
Pryde, Noel, M.B., B.S., 1924 (Univ. Melbourne), Prince of Wales Hospital, Randwick.

For additional registration:

Shellshear, Joseph Lexden, M.D., 1929 (Univ. Sydney).

Names restored to register:

Fitzpatrick, Louis J., Lic.R.Coll.Phys., Edinburgh, 1881, Lic.Apoth.Hall, Dublin, 1880, Lic.R.Coll.Surg., Edinburgh, 1881, 11, Prince Albert Street, Mosman.
McIlroy, John Black, L.R.C.P., London, 1887, Lic.Soc.Apoth., London, 1886, Mem.R.Coll.Surg., England, 1888, Kendall, New South Wales.

Books Received.

PRACTICAL MASSAGE AND CORRECTIVE EXERCISES WITH APPLIED ANATOMY, by H. Nissen; Fifth Edition, revised and enlarged by Harry Nissen; 1929. Philadelphia: F. A. Davis Company. Royal 8vo., pp. 27[illegible], with illustrations. Price: $2.50 net.

A PRACTICAL TREATISE ON DISORDERS OF THE SEXUAL FUNCTION IN THE MALE AND FEMALE, by Max Hühner, M.D.; Third Edition; 1929. Philadelphia: F. A. Davis Company. Royal 8vo., pp. 35[illegible]. Price: $3.00 net.

STARLING'S PRINCIPLES OF HUMAN PHYSIOLOGY; Fifth Edition, edited and revised by C. Lovatt Evans, D.Sc., F.R.C.P., F.R.S.; the chapters on the Central Nervous System and Sense Organs revised by H. Hartridge, M.A., M.D., Sc.D., F.R.S.; 1930. London: J. and A. Churchill. Royal 8vo., pp. 1054, with illustrations. Price: 21s. net.

Diary for the Month.

JAN. 7.—New South Wales Branch, B.M.A.: Council.
JAN. 7.—New South Wales Branch, B.M.A.: Organization and Science Committee.
JAN. 14.—New South Wales Branch, B.M.A.: Ethics Committee.
JAN. 14.—New South Wales Branch, B.M.A.: Post-Graduate Work Committee.
JAN. 21.—New South Wales Branch, B.M.A.: Executive and Finance Committee.
JAN. 22.—Victorian Branch, B.M.A.: Council.
JAN. 28.—New South Wales Branch, B.M.A.: Medical Politics Committee.

Medical Appointments Vacant, etc.

FOR announcements of medical appointments vacant, assistants, *locum tenentes* sought, etc., see "Advertiser," page xx

DOWERIN DISTRICT, WESTERN AUSTRALIA: Medical Officer.
GOODOOGA DISTRICT HOSPITAL, NEW SOUTH WALES: Medical Officer.
SYDNEY HOSPITAL, SYDNEY, NEW SOUTH WALES: Honorary Aural Surgeon.
THE BRISBANE AND SOUTH COAST HOSPITALS BOARD, QUEENSLAND: Honorary Vacancies.

Medical Appointments: Important Notice.

MEDICAL practitioners are requested not to apply for any appointment referred to in the following table, without having first communicated with the Honorary Secretary of the Branch named in the first column, or with the Medical Secretary of the British Medical Association, Tavistock Square, London, W.C.1.

BRANCH.	APPOINTMENTS.
NEW SOUTH WALES: Honorary Secretary, 21, Elizabeth Street, Sydney.	Australian Natives' Association. Ashfield and District United Friendly Societies' Dispensary. Balmain United Friendly Societies' Dispensary. Friendly Society Lodges at Casino. Leichhardt and Petersham United Friendly Societies' Dispensary. Manchester Unity Medical and Dispensing Institute, Oxford Street, Sydney. North Sydney Friendly Societies' Dispensary Limited. People's Prudential Assurance Company, Limited. Phœnix Mutual Provident Society.
VICTORIAN: Honorary Secretary, Medical Society Hall, East Melbourne.	All Institutes or Medical Dispensaries. Australian Prudential Association Proprietary, Limited. Mutual National Provident Club. National Provident Association. Hospital or other appointments outside Victoria.
QUEENSLAND: Honorary Secretary, B.M.A. Building, Adelaide Street, Brisbane.	Members accepting appointments as medical officers of country hospitals in Queensland are advised to submit a copy of their agreement to the Council before signing. Brisbane United Friendly Society Institute. Mount Isa Hospital.
SOUTH AUSTRALIAN: Secretary, 207, North Terrace, Adelaide.	All Contract Practice Appointments in South Australia. Booleroo Centre Medical Club.
WESTERN AUSTRALIAN: Honorary Secretary, 65, Saint George's Terrace, Perth.	All Contract Practice Appointments in Western Australia.
NEW ZEALAND (WELLINGTON DIVISION): Honorary Secretary, Wellington.	Friendly Society Lodges, Wellington, New Zealand.

Medical practitioners are requested not to apply for appointments to positions at the Hobart General Hospital, Tasmania, without first having communicated with the Editor of THE MEDICAL JOURNAL OF AUSTRALIA, The Printing House, Seamer Street, Glebe, New South Wales.

Editorial Notices.

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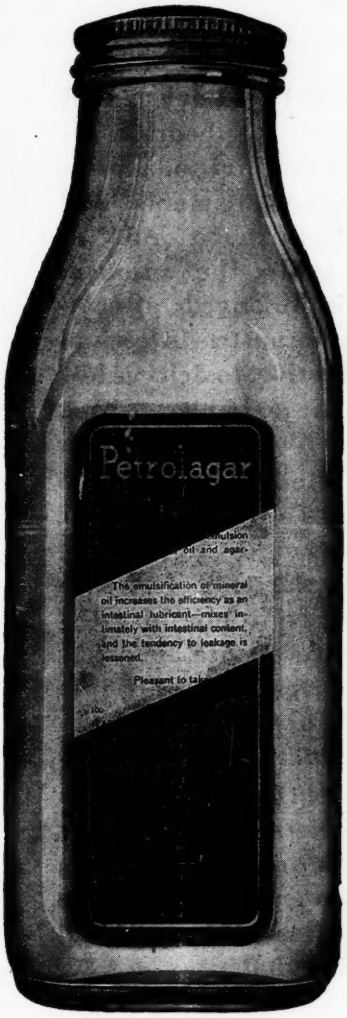
INDEX TO VOLUME II, 1929.

JULY TO DECEMBER.

INDEX TO ILLUSTRATIONS.

SPECIAL PLATES.



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